

**STUDENT NURSES' EXPERIENCES OF THE CLINICAL FIELD  
IN THE LIMPOPO PROVINCE AS LEARNING FIELD:  
A PHENOMENOLOGICAL STUDY**

by

**RIRHANDZU NORAH MONGWE**

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**PROMOTER: DR DM VAN DER WAL**

**JOINT PROMOTER: DR VJ EHLERS**

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Student number: 0681-674-6

## DECLARATION

I declare that **STUDENT NURSES' EXPERIENCES OF THE CLINICAL FIELD IN THE LIMPOPO PROVINCE AS LEARNING FIELD: A PHENOMENOLOGICAL STUDY** is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any institution.

**SIGNATURE**

(RIRHANDZU NORAH MONGWE)

**DATE**

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**STUDENT NUMBER:** 0681-674-6  
**STUDENT NAMES:** RIRHANDZU NORAH MONGWE  
**DEGREE:** DOCTOR OF LITERATURE AND PHILOSOPHY  
**DEPARTMENT:** HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA  
**PROMOTER:** DR DM VAN DER WAL  
**JOINT PROMOTER:** DR VJ EHLERS

## **Abstract**

The research question the researcher set out to answer was: *How do student nurses experience learning in the clinical field?* The research question stemmed from years of experience in nursing education and a concern about student nurses' involvement in the clinical area.

A phenomenological investigation was embarked upon involving principles from Wertz's (1983, 1984, 1985) *empirical psychological reflection*. The existential base-line for the research was stated as: *Human experience results in learning*. The base-line also supported the assumptions underlying the current research and are in line with phenomenological philosophy.

Participants were selected from the student nurse population in the Limpopo Province via convenience and purposive sampling. Five students from second through fourth year of training according to SANC Regulation R425 were selected.

Data were collected through in-depth interviews. One initial and one follow-up interview were conducted with each participant. Interviews were audio-taped and transcribed verbatim.

Data analysis at the idiographic and nomothetic levels was conducted through open coding, categorisation and constant comparative analysis.

Four major themes emerged from the data namely:

- Descriptive overview of clinical learning
- The lived experience of student nurses
- Motivational factors in clinical learning
- Erosive factors in clinical learning

*Awareness figured* as an all accommodating concept to theme and categories. It figured as a multi-dimensional concept that positions and orientates student nurses in the clinical setting. Awareness answers the student nurse's existential question:

*Where am I?*

Based on the findings OF the current research and guided by the concept of an integrated holistic awareness, conclusions were drawn and recommendations and guidelines were formulated relating to: nursing education, nursing management, cooperation between education and services, clinical teaching, future research and theory development.

## **KEY WORDS**

Awareness, clinical facilitation, clinical learning field (environment), connectedness, experiences, educational theory, learning, mindfulness, phenomenology, student nurses.

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## List of abbreviations

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LP	Limpopo Province
RSA	Republic of South Africa
SANC	South African Nursing Council
UK	United Kingdom
Unisa	University of South Africa
USA	United States of America

## List of appendices

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Appendix A	Letters requesting permission to conduct the study
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Appendix C	Letter of information for participants and an example of informed consent
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# Chapter 1

## Background to and overview of the study

### 1.1 INTRODUCTION

The researcher conducted this phenomenological study on the lived experiences of student nurses, in the Limpopo Province (LP) of South Africa, in relation to their clinical learning environments' learning experiences, to uncover the factors influencing learning in the clinical field. This study was conducted to describe and understand students' experiences of the clinical fields as learning experiences and ultimately to improve clinical facilitation thereby maximising the learning experiences of student nurses allocated to different clinical fields.

A student nurse referred to in this study is a nurse undergoing a four year integrated diploma course leading to registration as a nurse (general, psychiatry, community) and midwife, according to Regulation R425 of 22 February 1985, as amended (SANC 1985).

The existential baseline for this study was that whatever the individual does, he or she learns continuously; learning is the essence of being. The overall research question was: "How do you experience the clinical learning environment as learning experiences?"

### 1.2 BACKGROUND INFORMATION ON THE LIMPOPO PROVINCE

The point of outlining the background information on the LP is to orientate the reader and to ensure that he/she has an understanding of the "clinical world" of student nurses, which is constituted by the LP.

#### 1.2.1 Population

Statistics South Africa (2001) estimated the population of the LP at around 5 273 642 (5,2 million) people, which constitutes 11.8% of the total population of the Republic of South Africa (Statistics South Africa (2003). This shows 7% increase in the population for the period 1996 to 2001. This makes Limpopo the fourth most densely populated Province in South Africa according to both the 1996 and 2001 census. According to the

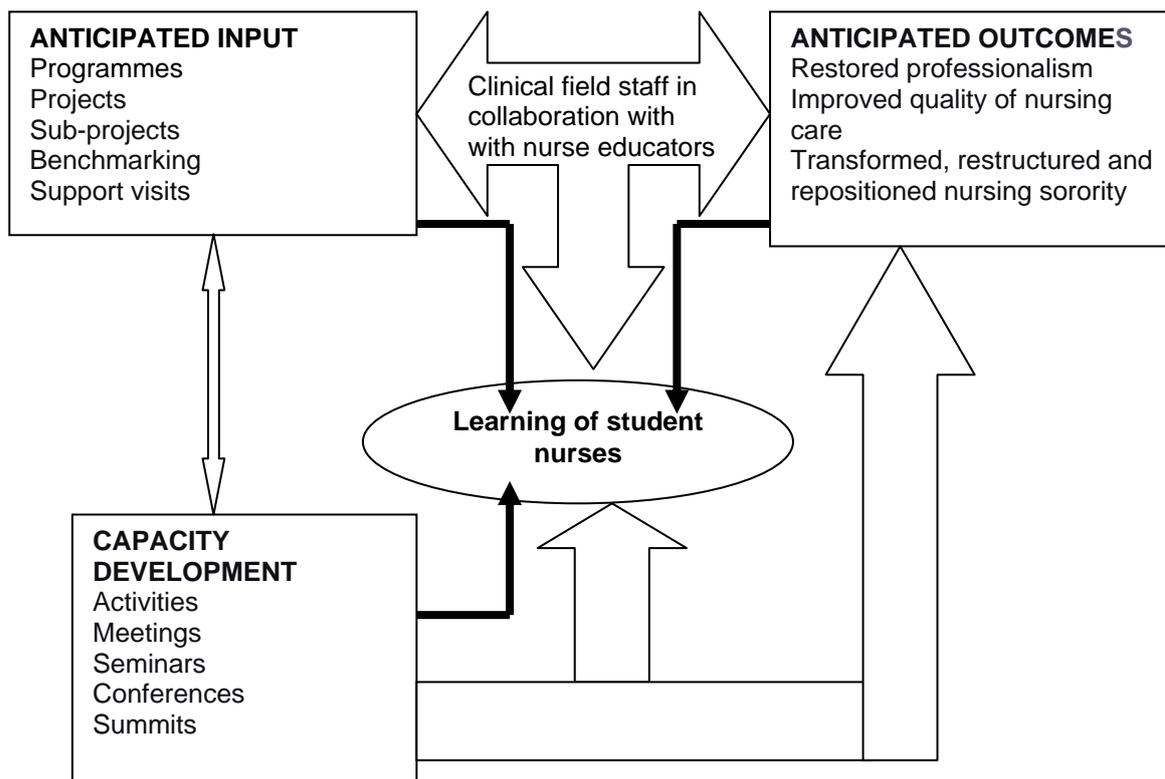
Department of Health and Social Development (2005), over 90% of the LP's population live in rural areas and are classified as being poor. This has a major impact on the service delivery and accessibility to service points. Despite improvements in the economic growth of the LP, the poverty levels remain high at 60%, particularly in Bohlabela and Sekhukuni districts where the dependency ratios are at 1:11 and 1:19 respectively (Limpopo Province Government 2005a:10).

### **1.2.2 Health care facilities**

The Department of Health and Social Development states in its annual performance plan that 43 hospitals and 22 health centres serve the LP. Fixed clinics and visiting points have increased from 302 to 479 between 1994 and 2005. As many as 127 new clinics were built while 63 existing clinics were upgraded. The increase in the number of Primary Health Care (PHC) facilities is an attempt to demonstrate the LP's commitment to the PHC approach aimed at increasing access to health care. This is evidenced by utilisation rates. For example, antenatal care (ANC) coverage stands at 93% while immunisation stands at 82%. Comprehensive Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) care, management and treatment special programmes are in place, aimed at improving the quality of services. Progress planned in the LP includes hospital revitalisation, development of hospitals as centres of excellence and modernisation of tertiary services (Limpopo Provincial Government 2005a:3).

### **1.2.3 Nursing services**

The Nursing Services Directorate has the responsibility of improving the quality of nursing services within the Province, through intensifying programmes and projects that will improve the quality of care. These projects include designing a model to act as a vehicle through which the Nursing Services Directorate could facilitate the restoration of improved quality nursing care, and the transformation of nursing practice, leadership and management (Limpopo Provincial Government 2005b:5). Figure 1.1 shows the anticipated input and outcome, and the capacity development initiatives, which, were put in place by the LP's Nursing Directorate within the clinical environments to improve patient care.



**FIGURE 1.1**  
**LIMPOPO NURSING DIRECTORATE: PRACTICE FRAMEWORK MODEL**  
(Limpopo Provincial Government 2005b:5)

Different projects and sub-projects selected for implementation include:

- quality management projects
- professional practice projects
- nursing management projects

These projects commenced in July 2001, were officially launched in November 2005 and they were implemented while the researcher was gathering data. All of these have a bearing on the learning milieu of student nurses within the clinical field.

How these might impact on the learning of students within the clinical area was not clear. An investigation into student nurses' lived experiences during the implementation of these projects was thus justified as such implementation implies change.

## **1.2.4 Nursing education offered in Limpopo**

### **1.2.4.1 General training background**

Different educational programmes for training and education of nurses are provided in the LP, including the diploma in:

- ophthalmic nursing
- health assessment, treatment and care
- midwifery
- general nursing (bridging course)
- nurse (general, community, psychiatric) and midwife (Limpopo Provincial Government 2005a:79)

However, the focus of this study is directed only at student nurses undergoing the four year integrated diploma course leading to registration as a nurse (general, psychiatry, community) and midwife, according to Regulation R425 of 22 February 1985, as amended.

The reason for selecting these programmes was to understand student nurses' experiences since as skilled and future professional nurses, it is expected of them to have the ability to lead as well as to provide guidance to student nurses within the clinical learning environment after the completion of training.

Taking the training and education of nurses into account, performance indicators were developed in order to measure whether there is progress in relation to the set targets. Table 1.1 reflects examples of indicators, which are used to measure the performance of training and educational programmes.

<b>TABLE 1.1</b> <b>NURSING EDUCATION PERFORMANCE MEASURE</b> (Limpopo Provincial Government 2005a:81)								
<b>Strategic objective</b>	<b>Measurable objective</b>	<b>Performance measure</b>	<b>Actual 2002/2003</b>	<b>Actual 2003/2004</b>	<b>2004/2005 Estimate</b>	<b>2005/2006 Target</b>	<b>2006/2007 Target</b>	<b>2007/2008 Target</b>
To provide nurse training	Basic diploma programmes	% of student nurses passed	70%	88%	90%	98%	98%	98%
	Graduate entrants from formal training courses	% of first year entrants who graduated	70%	80%	85%	90%	95%	100%
		% of nurses registered with SANC at the end of the programme	70%	80%	85%	90%	95%	100%
		% of nurses in public service posts within three months	Establish baseline	100%	100%	100%	100%	100%
	Acquisition of computers and software support materials	% of campuses with complete computer and software support materials	0	33%	66%	100%	100%	100%
	Campuses with maintenance plan	Number of campuses implementing maintenance plan	0	100%	100%	100%	100%	100%

#### **1.2.4.2 Distribution of student nurses**

Student nurses in the LP College of Nursing Education are assigned in to the clinical field in line with the South African Nursing Council's (SANC) minimum requirements concerning the education and training of student nurses in the R425 programme leading to registrations as a nurse (general, psychiatry and community) and midwife. Detailed information is presented in section 3.3.3.2.

Student nurses are distributed among three campuses (Thohoyandou, Sovenga and Giyani) of the Limpopo Nursing College in order to ensure that by the end of their training, they had acquired all the clinical learning experiences from various facilities around the Province. These experiences include:

- assessment and diagnoses
- planning with a view towards promoting, maintaining and restoring optimal functioning of the patient
- implementing nursing care
- evaluation of nursing care rendered (SANC 1992a:11)

Table 1.2 shows the distribution of student nurses within the three campuses as well as the clinical learning environment. Data were obtained from the curriculum documentation of Limpopo College of Nurses.

<b>TABLE 1.2</b> <b>DISTRIBUTION OF STUDENT NURSES ACCORDING TO NURSING CAMPUSES AND CLINICAL LEARNING ENVIRONMENTS</b> (Limpopo College of Nurses Curriculum Document 2004)			
<b>CAMPUS</b>	<b>HOSPITALS</b>	<b>LEVELS OF STUDENT NURSE</b>	<b>COURSES</b>
THOHOYANDOU	Hayani Siloam Tshilidzini Donald Frazer	First Year Fourth year	Basic Nursing Care Fundamental Nursing Science Ethos and Professional Practice Medical and Surgical Nursing General Nursing Science Community Nursing Science Psychiatric Nursing Science Midwifery
SOVENGA	Mankweng Lebowakgomo Pietersburg Mokopane	Second year Fourth year	Basic Nursing Care General Nursing Science Medical and Surgical Nursing General Nursing Science Community Nursing Science Psychiatric Nursing Science Midwifery
GIYANI CAMPUS	Tintswalo Nkhensani Elim	Third year Fourth year	Basic Nursing Care Medical and Surgical Nursing General Nursing Science Community Nursing Science Psychiatric Nursing Science Midwifery

### **1.2.4.3 Challenges**

Much as the Department of Health and Social Development implement the abovementioned plans and note improvements regarding training and education of nurses in the LP, there remain general challenges, which include:

- inadequate residential accommodation, having a negative impact on the distribution of student nurses in the clinical learning environment for clinical learning experiences
- inadequate training facilities, contributing to shortages of teaching staff
- failure to retain trained personnel impacting on the availability of trained staff to help student nurses within the clinical learning environments (Limpopo Provincial Government 2005a:79)

Although there are no absolute figures given to reflect the above mentioned challenges in the LP, these challenges appear to have negative impacts on the learning of student nurses as discussed during nursing education meetings during 2003 and 2004.

### 1.2.5 General quality improvement measures in the Province

The quality of service is improved through, amongst others, the measures outlined in table 1.3.

<b>TABLE 1.3</b> <b>SUMMARY OF SERVICE DELIVERY IMPROVEMENT INITIATIVES IN LIMPOPO</b> (Limpopo Provincial Government 2005a:80)	
<b>Organisational Development</b>	Effective implementation of performance management systems Capacity building and training programmes On-going review and re-engineering of institutional systems and structures. Building nursing research capacity.
<b>Service delivery improvement plan</b>	Batho-Pele and quality assurance programme The implementation of service standards and citizen's reports
<b>Health technology</b>	Utilisation of health information system and tele-health
<b>Physical facilities management</b>	Maintenance
<b>Monitoring and evaluation</b>	Monthly, quarterly and annual report

### 1.3 BACKGROUND OF THE PROBLEM

Poor quality patient care is often associated with inadequate exposure of professional practitioners during training as student nurses. Complaints about poor patient care, neglect of patients and negative attitudes towards patients are often reported in the suggestion boxes (Bathopele Reports 2002).

How come these incidents happen if effective clinical facilitation and learning of student nurses are taking place within these clinical fields? From the researcher's experience, the questions most frequently asked by those involved in clinical facilitation relate to whether the focus is on what students learn or whether they are being *taught* in the clinical field. Thus, whether learning in the clinical field is student-centred and directed by student needs or whether it is centred on and directed by predefined curricular contents appear to be unclear. Further problems become apparent when a registered nurse cannot supervise patient care, thus providing inadequate guidance to student nurses when allocated within the clinical learning environment.

In the same vein, from the study conducted by Lowane (1990) regarding nursing students' perceptions of clinical learning experiences in the LP, it was found that qualities such as

- ward organisation and management
- preparation for leadership
- problem-solving
- development of interpersonal competencies

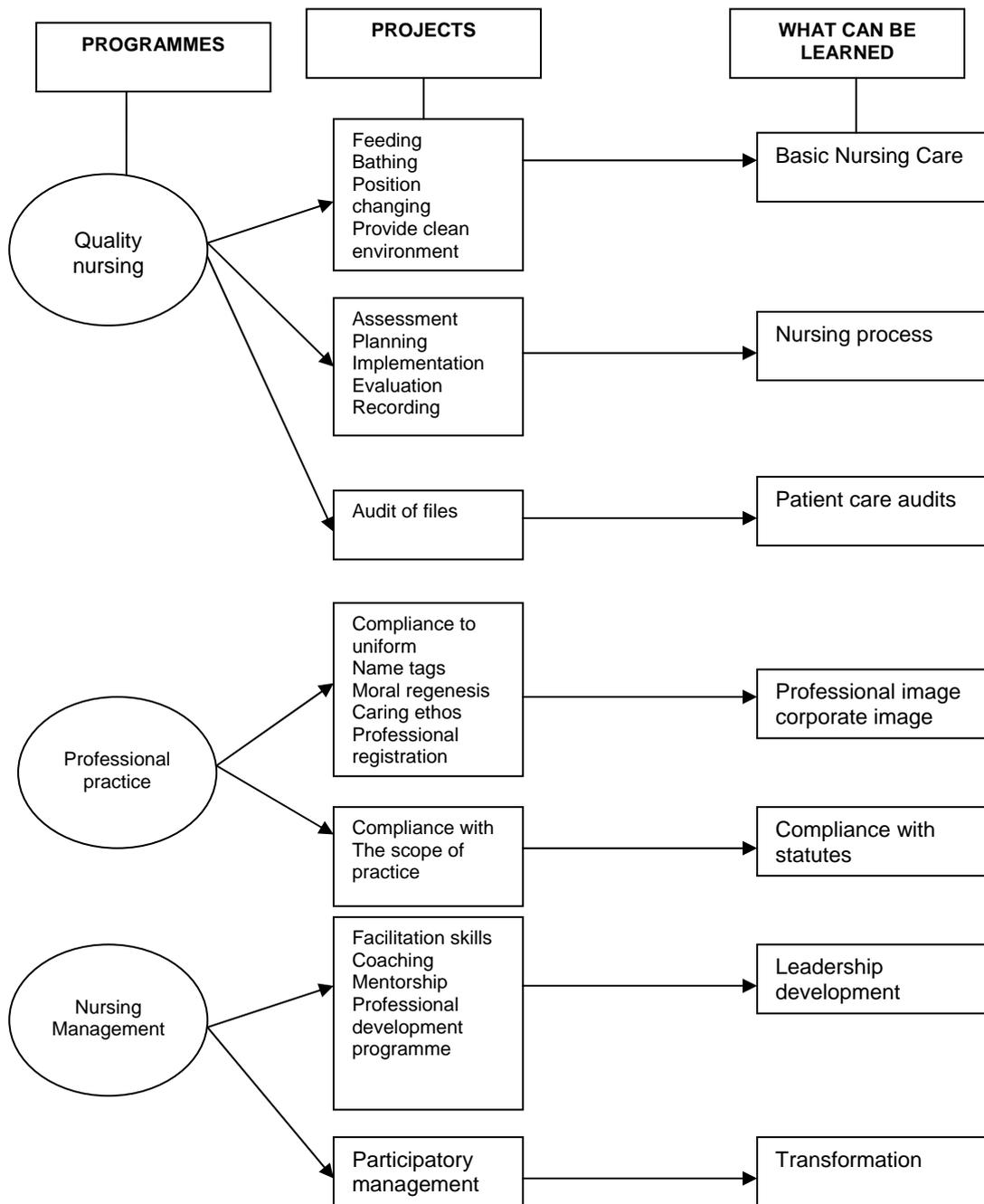
had gained very little attention during training in the health services in the former Gazankulu, now falling within the LP (Lowane 1990:58).

On the other hand, it was indicated in the minutes of a meeting held by nurse educators and nurse managers in the LP on 11 November 1999 that most student nurses following the four-year integrated diploma course leading to registration as a nurse (general, psychiatry, community) and midwife, according to Regulation R425 of 22 February 1985, as amended, dodged from their allocated clinical environments. Tutors who removed student nurses from their allocated clinical environments without notifying facilitators were said to intensify the problem. Student nurses concerned confirmed this matter. Mongwe (2001:114) in the LP articulated dodging of student nurses during clinical placements with a lack of interest in learning clinical skills. For instance, in this study, participants remarked: *student nurses don't even stay in the wards as they go to phone, go for tea forever and come back after some hours.*

Of special concern is the learning of student nurses within the clinical learning environment, and what they experience in this environment. As student nurses are allocated to the clinical learning environment, they are expected to gain learning experiences from the learning opportunities available to them in the clinical environment.

According to the Member of the Executive Council (MEC) in the Limpopo Provincial Department of Health and Social Development's statement, in the various forums, the Department has interacted with communities regarding quality of care. All the complaints and suggestions were considered through the establishment of the LP's Nursing Directorate in July 2001 to look into ways of improving quality of care. The core of the interventions was to set up processes that could intensify programmes and projects regarding quality of care with particular reference to nursing care and nursing professionalism within the clinical environment (Limpopo Provincial Government 2005b:iii).

Based on the fact that patients in health services are most of their time in the hands of nurses that form more than 50% of the entire personnel of the Department, nurses in the Limpopo Provincial Government displayed commitment to a transformation of nursing services in collaboration with nursing education, through coining a commitment statement such as "*Let our services speak for us*" (Limpopo Provincial Government 2005b:5). This commitment became evident when the support from both nurse managers from clinical learning environments and nurse educators from the three campuses and nursing schools supported the Nursing Services Directorate to develop, pilot and implement the model for the improvement of quality nursing care, impacting on the learning of student nurses. Figure 1.2 displays the programmes, projects and what student nurses could learn during the implementation of these projects.



**FIGURE 1.2**  
**NURSING PRACTICE MODEL ELEMENTS**  
 (Limpopo Provincial Government 2005b:6)

However, even though these improvement initiatives are taking place within the clinical fields where the student nurse are placed, the question still is:

*How is the clinical field experienced as a learning field?*

This may appear to be a simple question. However, one cannot understand student nurses' experiences except when these experiences are shared by student nurses themselves. Student nurses' lived experiences of the clinical field have, however, not been researched in the LP.

Aspin (1997:1) refers to an experience as: the data that people receive through the medium of their various sense organs, providing the recipients of such data with evidence of the existence of a world of real objects. According to Vakalisa, Van Niekerk and Gawe (2004:157), individuals' experiences influence their directions in life. This is in line with the intentions of the Nursing Services Directorate in the LP through intensifying professional practice outlined in the model according to figure 1.1 and figure 1.2 respectively.

During nurse managers' and nurse educators' forum discussions held by the nursing directorate of the LP (since 2001) regarding providing opportunities for student nurses within the clinical learning environments problems identified were:

- poor accompaniment
- lack of clinical facilitation within clinical learning environments
- lack of guidance

With regard to the above issues, the SANC (1992a) stated explicitly in its guidelines that

- all nursing science subjects with practical components are presented with accompaniment, over the whole duration of the course
- active involvement of a student nurse in nursing patients as a member of the nursing and health team, is required in order to practise and master nursing (general, psychiatric and community) and midwifery skills (SANC 1992a)

According to the Limpopo Provincial Government (2004:13) problems which were considered to be erosive to the learning of student nurses prior to the establishment of the nursing directorate in 2001 included:

- lack of acknowledgement of the professional image manifested by not wearing uniforms
- undermining of authority
- unsatisfactory basic nursing care provided to patients

Erosive factors to learning within the clinical learning environment seem to exist universally, as reflected in international publications. Problems associated with insufficient knowledge also became a focal point in published works. Lee (1996:1131) sustains this view by indicating that nurse teachers feel ill-equipped to deal with the clinical teaching situation due to lack of confidence and knowledge. Duke (1996:410) also shares these sentiments by pointing out that clinical instructors' lack of educational qualifications contributes to their being unprepared for the complexities of their teaching role.

If a registered nurse, or a clinical instructor as a facilitator have insecurities about guiding a student nurse, both facilitation and learning could be eroded.

More research has shown, that learning within the clinical learning environments could be eroded by student nurses' own approach to their placement within the clinical learning environment in England (Baillie 1993:1046). While in the United Kingdom (UK) Howkins and Ewens (1999:47) found that the negative aspect was one of frustration. In the study conducted by Carlson, Kotze, Van Rooyen (2003:35) in the Republic of South Africa (RSA), student nurses verbalised that they were not getting the opportunity to practise skills with each other due to shortages of staff, or wards which were too busy.

The question then becomes one of what are the lived experiences of student nurses within the clinical learning environments in the LP?

Although studies focusing on lived experiences of student nurses in other countries were conducted, differences might play a role and that as far as the LP is concerned, no such study has been conducted. Students and their experiences need to be "understood" not in terms of foreign literature only, but also in terms of local investigations.

## 1.4 MOTIVATION FOR THE STUDY

The researcher has contemplated what the lived experiences of student nurses as learning experiences are in the clinical learning environment. In conducting the present study the researcher wished to explore and describe the lived experiences of students in the clinical learning environment in the LP.

The information obtained through this study would assist the researcher to identify and describe those clinical learning experiences and environments, which should enable student nurses to gain positive learning. Furthermore, the researcher hoped that factors that either promote or erode clinical learning could be uncovered. Since no study of this nature has been conducted in the LP, the results could also broaden a body of knowledge about nursing education and clinical practice in the LP.

The researcher also conducted this study with the hope of getting to know more about the learning environment and what is experienced in the everyday world of student nurses and not about what anyone says or thinks about the clinical environment as learning environment.

Bloom (1964) understands clinical learning environments as the conditions, forces, and external stimuli, which impinge on the individual (Dunn & Burnett 1995:1167). Carlson et al (2003:32) elaborate on this by stating that it is the environment in which student nurses learn through performing skills related to the needs of patients.

The researcher had also been motivated to conduct the current study by the information obtained from the literature regarding student nurses and learning in general.

Many studies have attempted to understand the experiences of student nurses and the way it is influenced (Baillie 1993; Hart & Rotem 1994; 1995; Duke 1996; Nehls, Rather, & Guyette 1997; Neill, McCoy, Parry, Cohran, Curtis & Ransom 1998; Read 1999). These investigations provided an important beginning to understanding the complexity of experiences related to the clinical learning environment.

The literature also indicates attributes of the clinical learning environment that promote learning, including:

- autonomy and recognition of students (Wilson 1994:85; Hart & Rotem 1995:6; Dumas, Villeneuve & Chevrier 2000:252; Gray & Smith 2000:1546; Tanner 2002:52)
- providing for job satisfaction (Hart & Rotem 1995:6; Dumas et al 2000:251)
- displaying role clarity (Hart & Rotem 1995:6; Edmond 2001:257; Carlson et al 2003:36)
- reflecting quality of supervision (Tanner 2002:51; Bezuidenhout 2003:19; Carlson et al 2003:38)
- reliable peer support (Byrd, Hood & Youtsey 1997:351; Neill et al 1998:18; Pollard & Hibbert 2004:40)
- learning opportunities (Hart & Rotem 1995:7; Gray & Smith 2000:1545; Little 2000:393; Pollard & Hibbert 2004:41)

Implied in the research question are whether students in the LP also experience these and whether any other experiences form part of their repertoire of experience.

Many researchers acknowledge the benefits of clinical learning experiences in an educational programme (Laschinger 1992:112; Girot 1993:115; Dunn & Burnett 1995:1166; Massarweh 1999:44; Nahas, Nour & Al-Nobani 1999:639; Read 1999:8; Taylor 2000:173).

These benefits include that student nurses:

- are challenged to try new modalities of care, which provide them with abundant experiences in learning clinical skills (Laschinger 1992:112; Dunn & Burnett 1995:1166; Massarweh 1999:44; Read 1999:8)
- learn to tolerate the ambiguities within the clinical learning environment (Nahas et al 1999:639; Taylor 2000:173)
- are socialised professionally (Massarweh 1999:44)
- develop specific competencies (Laschinger 1992:113; Neill et al 1998:20; Pollard & Hibbert 2004:42)

Again, the overall research question is open to investigating the above issues and additional issues. The current study gives attention to the experiences of student nurses in the LP involved in the education and training in terms of Regulation R425 of 22 February 1985, preparing a student nurse to be registered as a nurse (general, psychiatry, community) and midwife as amended. Based on this, the subject curriculum outlined in R425 provides the reality of learning experiences a student nurse is expected to acquire within the clinical learning environment. These are delineated in section 3.3.3.2.

## **1.5 THE PROBLEM STATEMENT**

Student nurses are allocated within the clinical learning environments in the LP to acquire clinical skills. On the contrary it was indicated in the minutes of a meeting held by nurse educators and nurse managers in LP on 11 November 1999 that most student nurses undergoing a four year integrated diploma course leading to registration as a nurse (general, psychiatry, community) and midwife, according to Regulation R425 of 22 February 1985, as amended, dodge from their allocated wards. Tutors who remove student nurses from their allocated wards without notifying facilitators within the clinical learning environments were said to intensify the problem. Student nurses concerned confirmed this matter (appendix E).

However, through the experience of being in the hospital which was utilised as a clinical facility for student nurses, it became evident that some student nurses usually disappeared from the clinical fields without the knowledge of their supervisors (Informal Encounter with Unit Managers' Complaints 2003). On the other hand, there were complaints from patients about the poor standard of care (Bathopele Suggestion Boxes 2002-2003) (appendix F).

With the improvement initiatives that were going on within the clinical fields as indicated in section 1.2, the question emerged as to whether student nurses are experiencing *learning* in the clinical field or not.

## **1.6 THE GUIDING RESEARCH QUESTION**

Based on the abovementioned information, the *guiding* research question to individual student nurses for this study is:

*How do you experience the clinical field as learning field?*

Alternatively:

*How do you experience learning in the clinical field?*

Essentially, the guiding research question focuses on the experiences of student nurses with the aim of understanding unfolding factors, which influence student nurses' learning within the clinical environment and what learning and facilitation essentially mean in this environment.

## **1.7 PURPOSE OF THE STUDY**

The purpose of this study consist of two parts,

- firstly, to gain an empirically based understanding of the lived experiences of student nurses in the clinical field as learning experiences in the LP
- secondly, to propose guidelines for enhancing learning within these clinical fields

## **1.8 RESEARCH OBJECTIVES**

The research objectives of this study are to:

- explore the question, what are student nurses' lived experiences of the clinical learning environment as learning experiences?
- discover a truthful picture of experiences of student nurses at second, third and fourth level regarding their experiences in the clinical environment as learning experiences
- describe the experiences of student nurses of the clinical learning environment, to come up with theory about these experiences as well as guidelines to improve clinical facilitation and learning

- understand more fully the structure, and meaning of student nurses' experiences as it is immediately experienced

## **1.9 SIGNIFICANCE OF THE STUDY**

The current study has the potential to contribute relevant information in the following areas.

### **1.9.1 Significance for learning of student nurses**

This research is significant since it could answer the question such as whether student nurses experience learning or not within clinical learning environments in line with the existing background of the problem outlined in section 1.3.

### **1.9.2 Significance for the clinical learning environments**

The findings of this study could contribute to better understanding of the nature of the clinical learning environment in the LP and bring to light measures to appropriate the clinical environments towards learning, which in turn could improve the quality of student nurses' learning.

### **1.9.3 Significance for nursing education**

Knowing and understanding the dynamics involved in the clinical learning environment and learning could illuminate relevant didactic elements that are important for student nurses' learning.

### **1.9.4 Significance for nursing research**

The findings of this research could stimulate further research at provincial and national level. Detailed information is given in section 8.9.1.

## **1.10 DEFINITIONS OF TERMS**

The central concepts for the current study are as follows:

### **1.10.1 Experience**

Experience is an actual observation of, or practical acquaintance with, facts or events which could be regarded as eroding or gaining knowledge and skill resulting from this (*The Readers' Digest Oxford Dictionary 1993:519*). Phenomenologically, Streubert and Carpenter (1999:44) hold that it is the lived experience that presents to the individual what is true or real in his/her life.

### **1.10.2 Facilitation/clinical facilitation**

According to the *Reader's Digest Oxford Dictionary* (1993:529), to facilitate signifies to make easy or less difficult or further promote or advance. With regards to clinical facilitation, Mongwe (2001:94) supports this by stating that facilitation denotes sharing responsibility for learning by the facilitator and the student nurse by guiding, involving, assisting and supervising.

### **1.10.3 Clinical learning environment/clinical field**

Carlson et al (2003:32) define the clinical learning environment as an environment in which student nurses perform skills related to the needs of patients. According to White and Ewan (1991:143), the environment for clinical learning should be real and involve the clinical staff so that student nurses have resource persons at hand.

This study refers to the clinical learning environment as the practical situation where there is an interaction of clinical staff and patients/clients with student nurses for the purpose of acquiring learning experiences and gaining skills.

### **1.10.4 Student nurse**

This study defines a student nurse as a nurse in the Limpopo College of Nursing undergoing a four-year integrated diploma course leading to registration as a nurse (general, psychiatry, community) and midwife, according to Regulation R425 of 22 February 1985, as amended.

## **1.11 ASSUMPTIONS**

Assumptions are defined as statements taken for granted or considered to be true, even though they have not been scientifically tested (Burns & Grove 2001:790).

Assumptions are derived from phenomenology and are related to existential philosophy. To this end, theoretical-conceptual, methodological-technical and ontological assumptions were posited for this study.

### **1.11.1 Theoretical-conceptual assumptions**

According to Mouton and Marais (1992:147), theoretical-conceptual assumptions denote commitments to the truth of the theories and laws of a particular paradigm. In addition to this, Creswell (1994:162) states that qualitative research focuses on the process that is occurring as well as the product outcomes.

With regard to the present study it was assumed that:

- a student nurse as a person is coexisting while co-constituting rhythmical patterns with the clinical learning environment
- a person is an open being, freely choosing meaning in a situation, bearing responsibility for decisions
- a student nurse can therefore transcend multidimensionally with possibilities
- the phenomenological method is rooted in the assumption that knowledge of a lived experience becomes known through persons' descriptions of the reality for them (Smith 1989:16)

### **1.11.2 Methodological-technical assumptions**

These assumptions pertain to the criteria regarded as scientific, and to the methods and instrumentation by means of which a given view of what is scientifically valid may be realised (Mouton & Marais 1992:147). Therefore, Creswell (1994:7) states that in methodological-technical assumptions, the question about the accuracy of the information may not surface in a study, or, if it does, the researcher talks about steps for

verifying the information with informants or triangulating among different sources of information, to mention a few techniques available.

Under this point it is assumed that in-depth phenomenological interviews as well as conducting follow-up interviews with participants brought to light that

- the application of phenomenology and existentialism are imperative for the study of individual experiences
- unstructured interviews with student nurses and experiential descriptions of clinical learning environments will elicit the required information from the participants
- being in the world, the world becomes real through contact with it, knowing shapes experienced
- a composite of realities, access to realities is a matter of locating and using forms of expression which could give the researcher access to student nurses' realities
- what is logically inexplicable might be existentially real and valid (Swanson-Kaufmann & Schonwald 1988:98)

### **1.11.3 Ontological assumptions**

Mouton and Marais (1992:147) state that in ontological assumptions, the nature of research objects is involved. Creswell (1994:4) substantiates this by stating that the only reality is that constructed by the individuals involved in the research situation. The attempt is therefore to understand not one, but multiple realities. Meanings and interpretations are negotiated with human data sources because it is the participants' realities that the researcher attempts to reconstruct (Lincoln & Guba 1985; Merriam 1988 as cited in Creswell 1994:162). Recognising that reality is dynamic, is the first step in establishing a truly humanistic perspective of research (Streubert Speziale & Carpenter 2003:3).

In this regard it is assumed that:

- an individual student nurse can reflect and verbalise role experiences and views regarding the clinical learning environment

- qualitative researchers can report faithfully on these realities, and on voices and interpretations of participants (Creswell 1994:4)

## **1.12 RESEARCH METHOD**

In line with the introductory nature of the present chapter a brief overview, highlighting the major issues relating to the research method and design, follows.

A phenomenological approach was chosen for this research. According to Streubert Speziale & Carpenter (2003:51), phenomenology is a science with the purpose to describe particular phenomena, or the appearance of things, as lived experiences. The focus of phenomenological philosophy and methodology are to understand the response of the whole human being, not just understanding specific parts of behaviours. Consequently, phenomenological research is based on the philosophical assumption that espouses the idea that there is no single reality - each individual has his/her own reality (Girof 1993:115; Lehana & Van Ryn 2003:27).

In addition, reality is considered to be subjective, thus an experience is considered unique to the individuals (Streubert Speziale & Carpenter 2003:10). However, Polit and Hungler (1995:197) point out that some phenomenologists assume that there is an essence that can be understood, in much the same way that the ethnographers assume that cultures exist.

In true qualitative and phenomenological fashion, the researcher gathered data through in-depth interviews. This enabled the researcher to arrive at the different experiences of student nurses relating to the clinical learning environment as learning experience. The phenomenology is explicated in detail in chapter 2.

### **1.12.1 Research design**

A research design is an overall plan for collecting and analysing data, including specifications for enhancing the internal and external validity of the study (Polit & Hungler 1995:32; Seaman 1987:169). The design used to explore the experiences of student nurses in the clinical environment, is a qualitative research design, of

phenomenological, descriptive and contextual nature. The research design is described in more detail in chapter 4 of this thesis.

### **1.12.2 Population**

Population refers to all elements that meet certain criteria for inclusion in a study (Burns & Grove 1993:236).

With regard to the present study, the term *population* refers to all student nurses in the Limpopo College of Nursing, registered for the diploma course leading to registration as a nurse (general, psychiatry, community) and midwife, according to Regulation R425 of 22 February 1985, as amended. Chapter 4 contains full details on this issue.

### **1.12.3 Sampling**

A convenience and purposive sample was drawn from student nurses available at the time of the research at the campuses where data were collected. Polit and Hungler (1995:232) refer to convenience sampling as the selection of the most readily available people as participants in a study. Burns and Grove (1997:303) articulate this by stating that in convenience sampling, participants are included in the study, because they happen to be in the right place at the right time.

With regard to the purposive aspect of the sample, Burns and Grove (1997:306) indicate, that purposive sampling involves the conscious selection by the researcher of certain participants to include in the study. "Certain" in this regard implies inclusion and exclusion criteria which are discussed in the following paragraph.

A convenience sample of five student nurses was drawn from student nurses within the Limpopo College of Nursing. Due to the fact that the study was phenomenological in nature, each participant was interviewed twice; during the second interview, questions were asked to clarify and verify the completeness and accuracy of the information. A substantial amount of data emerged from the interviews and a data supplement of 86 pages, containing the verbatim results of the interviews, was compiled (appendix G). From this data, themes, categories and sub-categories were compiled. This resulted in

4 main themes, 16 categories and 65 sub-categories, 53 sub-subcategories and 778 statements.

The following inclusion criteria were used to select participants for this study:

- A student nurse had to be registered at the Limpopo College of Nursing undergoing a four-year integrated diploma course leading to registration as a nurse (general, psychiatry, community) and midwife, according to Regulation R425 of 22 February 1985, as amended.
- A student nurse had to be in the second, third or fourth year of study.

Theoretical sampling of literature to augment the data elicited through interviews was also conducted. The researcher also returned and interviewed participants with recurring themes that had to be clarified. The number of items sampled in both cases depended on whether saturation of categories had been obtained.

Sampling techniques are discussed fully under section 4.3.2.

#### **1.12.4 Data collection approach**

The methodology for this research emphasises the following aspects:

- Data were gathered through formal open unstructured qualitative research interviews, and follow-up interviews guided by the analyses of previous interviews.
- Audio-taping was done.
- The data collection instrument included the interview schedule, and the researcher. As Polit and Hungler (1995:273) put it, although unstructured interviews are conversational in nature, this does not mean that they should be entered into casually. Purposeful conversations require advance thought and purposeful preparation.

Gordon (1997:146) emphasises that fundamental to the phenomenological method of investigation is the rigour accompanying its most basic exercise, bracketing. In accordance with the above notion, the researcher remained neutral with respect to the

belief or disbelief of the experiences of student nurses in the clinical learning environment. Furthermore, the researcher set aside previous knowledge and beliefs about clinical experiences to prevent those from interfering with pure descriptions of the phenomenon. Detailed information is discussed in section 4.5.

#### **1.12.5 Data recording**

Appleton (1993:893) recommends that dialogical encounters describing the experiences should be tape recorded to provide data for analysis. Field (1996:135) as well as Streubert and Carpenter (1999:59) elaborate on this by stating that high quality tape recording and verbatim transcriptions to increase the accuracy of data collection make data manageable.

Permission was obtained from each participant to tape-record the conversation in order to ensure accurate transcription. The researcher explained the rationale for tape-recording to each participant and also indicated that the tapes will not be made available to anyone except the researcher.

#### **1.12.6 Data analysis**

The researcher analysed data following Wertz's (1983) idiographic (individual) and nomothetic (combined) levels of data analysis. A detailed description hereof is given in chapter 5.

#### **1.12.7 Measures to ensure trustworthiness**

As pointed out in Krefting (1991:215), researchers need alternative models appropriate to qualitative designs that ensure rigour without sacrificing the relevance of the qualitative research. The term reliability and validity are quantitative research concepts, which are replaced by trustworthiness in qualitative research (Agar 1986 as cited by Krefting 1991:215). However, in the current study, trustworthiness that may be operationalised under four strategies, namely credibility, transferability, dependability and confirmability as outlined by Lincoln and Guba (1985:301) were followed to enhance trustworthiness. Full descriptions of these strategies and the way in which the researcher implemented each of these are discussed in section 4.8.

### 1.13 ETHICAL CONSIDERATIONS

Ethics are defined as a system of moral values, that are concerned with the degree to which research procedures adhere to professional, legal, and social obligations to the research subjects (Polit & Hungler 1995:641), the institution at which the research was conducted and the integrity of the researcher.

Ethical issues relating to the current research are discussed in detail in chapter 3. This section outlines the ethical code of conduct adhered to during and after the current study, highlighting the following areas:

- Informed consent of the student nurses to participate.
- Anonymity.
- Ensuring confidentiality.

Louw and Edwards (1998:54) acknowledge the importance of informed consent by stating that researchers should obtain informed consent from participants before the research begins. A written explanation was provided to participants along with a written consent form. The researcher offered an explanation of the research, and the nature of, and the reasons for, the study. The methods and procedures to be used were explained clearly to prevent the threat of covert activity. Prior to the tape recording interviews the purpose of the study was clarified with each participant. Polit and Hungler (1995:119) warn that exposing research participants to experiences that result in serious or permanent harm is unacceptable. The researcher was prepared to terminate the research if there was a reason to suspect undue distress. The researcher, however, strove to avoid psychological harm by carefully phrasing questions and mindful probing of certain areas. Louw and Edwards (1998:54) caution that if the participants are worried about confidentiality, they may not give accurate information.

Participants were informed that the institutions and all participants will not be named, and the hospitals where the study conducted were given pseudonyms.

Detailed information regarding ethical considerations are described in section 4.7.

## **1.14 SCOPE AND LIMITATIONS OF THE STUDY**

Minor limitations were observed during the study that are congruent with the limitations mentioned by Giorgi (1983:148), namely four factors pertaining to the scope and limitations that must be considered:

- the constitution of the research situation
- the constitution of data
- the constitution of method
- the constitution of interpretation and communication procedures

### **1.14.1 The constitution of research situation**

According to Giorgi (1983:148), the first obvious thing to be noted is that the research situations or settings are not discovered 'ready-made' in the world, they have to be constituted or constructed by humans and they are usually developed for very specific purposes. The key point is that research situations cannot be understood merely in terms of their physical or even natural characteristics, but reference to the researcher's intents must also be included because the very existence of a research situation depends upon conscious human achievements. With regard to the above-mentioned limit, one often has to be reminded that a research situation is a specialised situation and that the human intention that constitutes it thematises it in such a way that it no longer remains for the researcher merely an ordinary everyday situation (Giorgi 1983:148).

A second obvious aspect to be noted is that one always pays a price for knowledge gained through research (Giorgi 1983:148). In addition, more happens in an everyday life situation than the research analogue can imitate and more happens in the research situation itself once it is conceived and actualised than the researcher can record.

With regard to the second limit, it is self-evident that one can only gain thorough or specific knowledge about one aspect of an event by ignoring other aspects of that event. The unfolding reality occurring in a situation is always richer than a human can grasp or know (Giorgi 1983:149).

These limits obviously do not invalidate research but they do remind us that one has to be careful when trying to speak of the implications of a research situation for an everyday situation because the two are not really identical.

The aforementioned analysis also reminds us that research situations are guided by something other than the research situation itself. It may be a theory, past knowledge, a model, a hunch, a perception or common sense Giorgi (1983:149).

#### **1.14.2 The constitution of data**

According to Giorgi (1983:151), in phenomenological research, it is not automatically given what the data will be. Whatever data turn out to be, it is the researcher who makes the decision, and again, presumably, in terms of how the phenomenon presents itself and in terms of the criteria being accepted as being representative of good scientific data. In empirical research, data are not simple, ready-made givens, but are constituted to be such by the researcher, and varied degrees of freedom are involved. This means that more happens in the research situation than the data express, but once the data are determined, one rarely speaks of the context within which the data were constituted. One usually speaks only of the data and their immediate implications.

Therefore, this is another limitation that all empirical research has to accept and bringing this to the full awareness should make one cautious about generalisations (Giorgi 1983:151).

This was confirmed in the present research with its limited scope regarding participants and context elimination principles applied during the purposive sampling of participants which resulted in selecting student nurses of a specific nature rather than the average subject from the target population. That is five student nurses, from second, third and fourth levels were interviewed where ten interviews were conducted.

### **1.14.3 The constitution of method**

Giorgi (1983:153) points out that the choice of method is crucial to the scientific venture, and mentions that if no method is available, then the researcher has to invent his/her own. Thus, once again there is a kind of slippage because more happens in the research situation than the selected method can tap. Giorgi (1983:153) gives the opinion that the idea subsequent to method is not to grasp the totality but to grasp an aspect of reality in a systematic and relative way. Thus, in addition to and correlative to public opinion, the research method includes conscious processes and achievements that play an important role in its construction. Giorgi (1983:154) mentions that a method can only be chosen in terms of a researchers' intention and that, in turn, depends upon how the phenomenon he or she is interested in, manifests itself.

With regard to obtaining the more appropriate method, Giorgi (1983:162) advises researchers that the most direct approach would be to attempt to discover the experienced reality of the participants by obtaining their descriptions. In line with Giorgi's (1983) advice, the researcher in the present study guided the participant during the interview to reflect their own experiences about the clinical learning environment.

### **1.14.4 The constitution of interpretation and communication procedure**

According to Giorgi (1983:155), the primary responsibility for interpreting and communicating the results of the research belongs to the researcher. Furthermore, no set of data is so unequivocal that it can be interpreted in one way only. As a consequence, when the researcher has to indicate what the results mean, one line of thought had to be chosen over possible others. Further, if one conducts research, it is because one wants to communicate the results to a specific audience. The group that the researcher might have in mind, could ultimately influence and determine the presentation of the data.

All the aforementioned differences are basically due to differences in presuppositions concerning the human person and science, and relative weighting given to each. The parameters remain constant because there are always more interpretations than the one chosen (Giorgi 1983:164).

## **1.15 OUTLINE OF THE STUDY**

**CHAPTER 1:** Background to and overview of the study: background, problem statement, purpose, objectives, significance, assumptions, scope and limitations, ethical considerations and definition of concepts referred to in the study.

**CHAPTER 2:** Methodological framework: phenomenology.

**CHAPTER 3:** Preliminary literature review of relevant texts, articles and studies undertaken by other researchers pertaining to experiences of student nurses in the clinical learning environments.

**CHAPTER 4:** Research design, ethical consideration and data collection techniques.

**CHAPTER 5:** Data analysis.

**CHAPTER 6:** Presentation of data, themes and categories with specific literature support.

**CHAPTER 7:** Relating the emergent construct, themes and categories to existing theory.

**CHAPTER 8:** Implications, recommendation and conclusions resulting from chapters 5 and 6.

## Chapter 2

### Methodological framework: phenomenology

#### 2.1 INTRODUCTION

This section addresses a variety of methodological interpretations related to the discipline of phenomenological inquiry. It incorporates highlights of specific elements and interpretations of phenomenology. It also focuses on methodological concerns specific to conducting phenomenological investigations.

In view of the fact that learning, by doing in the clinical learning environment, depends on student nurses' being inspired to explore and construct their observations, and to be aware of the meaning of their experiences and consequences thereof for their future competence; this study focuses on the experiences of student nurses (learners) in the clinical learning environment.

According to Girof (1993:115) phenomenology, as a qualitative research method, is used to discover and understand the meaning of human life experiences or lived experiences through an analysis of subjects' descriptions of the situation.

#### 2.2 ORIGIN AND ESSENCE OF PHENOMENOLOGY

Jasper (1994:310) points out that phenomenology developed as a reaction to the reductionist approach in science (natural sciences proper and applied to the humanities in the form of positivism), which tended to explore factors in isolation and in an abstract fashion. As Rose, Beeby and Parker (1995:1126) put it: *phenomenology is rooted in the world view that reality is not separate from individual experience and thus respects the inner or subjective reality generated by the person. It is therefore incongruent with the objectives of rational empiricism.* According to Cohen (1987 as cited in Jasper 1994:310), Edmund Husserl (1859-1938) is generally acknowledged as the founding father of phenomenology, which he considered to be *the universal foundation of philosophy and science.* According to Jasper (1994:310), the starting point of phenomenology is with *things* themselves, which Husserl (1859-1938) views as the true example of what phenomena are. Smith (1989 as cited in Rose et al 1995:1124)

contends that for the phenomenologist, there is no objective reality, which can be known separately from individual experience and perception. Phenomena cannot be separated from the experience of *them*; therefore, the way to access phenomena is through prereflective descriptions of it, in the person's own words (Jasper 1994:310). Young, Taylor and McLaughlin-Renpenning (2001:14) corroborate this by stating that philosophy considers what humans can know through experiential evidence and reason, and that the development of theory is considered first in its philosophical context and then in terms of its specific knowledge domains and various branches of philosophy, namely, cosmology, ontology, and epistemology. At the level of the present research, in this regard, ontology and epistemology are important. Ontology examines the nature of being (social reality); and epistemology is the study of knowledge itself, for example, what it is, what its properties are, and why it has these properties (Young et al 2001:10). Cosmology is not addressed in the current study as cosmologists use telescopes, astronomical satellites, and other instruments to study the universe. The data that these instruments provide allow scientists to evaluate current theories and to come up with ideas to better explain the universe. Modern cosmologists are continuously calculating the age, density, and rate of expansion of the universe, which is not in accordance with the intent of the current study as it is qualitative in nature (*Encyclopedia* 2005). The correlation between epistemology and ontology include the fact that the knowledge process (epistemology) is an essential part of the process of constituting a life world (ontology), which is the life world of student nurses during clinical practice. Assumptions relating to ontology were discussed in section 1.11.3.

Further, according to (Becker 1992:11), the phenomenological viewpoint is based upon the following premises:

- One premise is that experience is a valid and fruitful source of knowledge. Any person's knowledge is based upon what that person experiences, whether it is firsthand experience or vicarious, second hand experience.
- A second premise of the phenomenological viewpoint is that our everyday worlds are valuable sources of knowledge. One can gain important insights into the essential nature of an event by analysing how it occurs in one's daily life.

- It should at this point be apparent that the choice of phenomenology as the approach and method along which the present research was conducted is justifiable. Phenomenology in this instance allowed for gaining understanding via emergent theory (narrative data) of the lived experiences of students of learning in the clinical field.

### 2.3 PHENOMENOLOGY DEFINED

According to Omery (1983 as cited in Jasper 1994), phenomenology is an inductive, descriptive research method, with the task of investigating and describing all phenomena, including human experience, in the way these phenomena appear. In whatever context the term phenomenology is used, it embraces its underlying beliefs and values, and uses particular ways of accessing the essence of phenomena, which reflect the experience from the subject's perspective (Jasper 1994:310). According to Merleau-Ponti (1962 as cited in Beck 1997), phenomenology is an inductive, descriptive research method that studies essences. As Polit and Hungler (1995:327) mention, the phenomenological researcher asks the question: *What is the essence of this phenomenon as experienced by these people?* Beck (1997:409) expands on this by stating that phenomenology asks question about the nature or the meaning of something; with regard to the present research, the essence of clinical learning.

Van den Berg (1997:204) also defines phenomenology as a descriptive study of things as they appear in the lived world. Compatible with Van den Berg's (1997) notion of the lived world, Rice and Ezzy (1999:15) present phenomenology as an attempt at providing an explanation of the *life-world* of the individual. This *life-world* includes taken-for-granted assumptions about everyday life, and the mundane, such as what clothes to wear, whether to write from the left to right, or how to deal with a friend. They further assert that each individual's life world is different, and individual's actions can be understood by situating him or her within the life-world of the actor thereby emphasising both the unique and the essential about the life-world of the individual. With regard to the present research, clinical experience and learning cover a large part of the student nurse's everyday life-world and lived world.

Streubert and Carpenter (1999:44) further emphasise the *inter-subjective corroboration* of phenomenology. This corroboration includes a system of interpretations helping us to perceive and conceive ourselves, our contacts and interchanges with others, and everything else in the realm of our experiences in a variety of ways, including to describe a method as well as a philosophy or a way of thinking (Streubert & Carpenter 1999:44). The concept of inter-subjective corroboration has important methodological implications as it forms the base of understanding self and other(s) and as such paves the way toward investigating the life and lived world of others via observation and interviewing. The latter formed the main data collection method during the present research. Inter-subjective corroboration between researcher and participant also provides for Jasper's (1994:311) concern that the research design in the case of phenomenological research needs to allow for accessing the meaning an experience has for the participant, and this needs to be preserved in identifying the 'essence' of the phenomenon. This in turn delivers us to the concept *bracketing*, of preserving the essence and identity of the phenomenon, as discussed in section 4.8.1.5.

Summatively Merleau-Ponti (1962) (in Streubert & Carpenter 1999:43) views phenomenology as:

- a study of essences in which all problems amount to finding definitions of essences: the essence of perception, or the essence of consciousness
- a transcendental philosophy which places in abeyance the assertions arising out of the natural attitude (personal experiences)
- also a philosophy for which the world is always "already there" before the reflection begins as an inalienable presence; and all its efforts are concentrated upon re-achieving a direct and primitive contact with the world, and endowing that contact with a philosophical status

It is thus evident why Streubert and Carpenter (1999:43) do not merely define phenomenology as a research method but also as a **science** of which the purpose is to describe particular phenomena, or the appearance of things, as lived experience.

## 2.4 HISTORICAL DEVELOPMENT OF PHENOMENOLOGY

Without going into too much detail, it is important to reflect on the development of phenomenology from its 19<sup>th</sup> century naissance onwards to catch up with the most important points of emphasis in the development of phenomenology. These also represent the gradual development in existential thought with which phenomenology is closely associated. Essentially these relate to a subtle change and variation in thought about the subject-object relationship. As is the case in many a philosophical line of thought, the emphases in each phase of development are not completely unique to that phase.

According to Streubert and Carpenter (1999:45), the development of the phenomenological movement consists of three phases as summarised in table 2.1

<b>PHASE</b>	<b>PROMINENT LEADERS</b>	<b>PRIMARY FOCUS</b>
<b>PREPARATORY</b>	Fratz Brentano (1838-1917) and Carl Strumpf (1848-1936).	➤ Intentionality
<b>GERMAN</b>	Edmund Hursel (1857-1938)  Martin Heidegger (1889-1976)	<ul style="list-style-type: none"> <li>➤ Essences</li> <li>➤ Intuiting</li> <li>➤ Phenomenological reduction</li> <li>➤ Intentionality as an arrow-like perception and later more in line with Schuler's value-ception</li> <li>➤ Existential-phenomenology</li> <li>➤ Hermeneutics</li> </ul>
<b>FRENCH</b>	Gabriel Marcel (889-1973), Jean Paul Sarte (1905-1980) and Maurice Merleau-Ponti (1905-1980)	➤ Embodiment and being-in-the-world (Strubert Speziale & Carpenter 2003:53-56; Von Eckartsberg 1986:14)

In what follows, the researcher describes in more detail the phenomenological view of human nature, as phenomenologists understood it, in order to penetrate more deeply the movement they set afoot.

## 2.5 PHENOMENOLOGICAL VIEW OF HUMAN NATURE

Becker (1992:23) expounds that a well thought through conceptualisation of human nature provides a solid foundation for applying phenomenology to life and research. In Becker's (1992:23) explanations, for the phenomenologists:

- People are active, intentional subjects who are aware of their worlds.
- Each person is inherently tied to a context and to other people, and factors help define the person.
- A person is a unity of mind and body, a perspectival scholar, and a co-creator of meaning who embraces and transcends *thrownness* by exercising situated freedom.
- Unique experiences generate common themes that enable phenomenologists to illuminate the essential structures of life.

A phenomenological view of human nature includes the concepts, which are displayed in table 2.2. These are primary concepts in conducting phenomenological studies.

<b>TABLE 2.2</b> <b>CONCEPTS FOR A PHENOMENOLOGICAL VIEW OF LIFE</b> (Becker 1992:21, Van den Berg 1997, Streubert & Carpenter 1999:330; Streubert Speziale & Carpenter 2003:56)	
<b>Being-in-the-world</b>	The belief that all art (whatever the individual creates or constructs, whether mental or physical tangible or intangible) are constructed on the foundation of perception, or original awareness of some phenomena (Merleau-Ponti 1956 as cited in Streubert & Carpenter 1999:330).
<b>Embodiment</b>	Through consciousness, one is aware of being-in –the world and it is through the body that one gains access to this world. One feels, thinks, taste, touches, hears and is conscious through the opportunities the body offers. At any point in time, and for each individual a particular perspective and/or consciousness exists, which is based on an individual's history, knowledge of the world, and perhaps openness to the world (Munhall 1989 as cited in Streubert Speziale & Carpenter 2003:56).
<b>Being-in-the-world-with-others</b>	Heidegger also understood people as “being-the-world-with-others”. He saw people as networks of interpersonal relationships. Any experience of oneself and another person occurs within an interpersonal framework (Becker 1992:14).
<b>Reflective</b>	Human nature reflects an openness that illuminates the world; each person is a clearing within which the world presents itself, not only are people aware of themselves and the world, they are aware of their awareness; they are self-reflective (Becker 1992:14).
<b>Active subject</b>	To be human is to be an active agent who organises and reacts to influencing forces. No matter how terrible the life events are that befall a person, phenomenologists contend that each person remains the only one who can live that particular life. People do not only react to life's events and forces, but they also shape events that shape their lives. Von Eckartsberg (1971) introduced the phrases “shaped shapers” and “shapers being shaped” to describe this aspect of human nature (Becker 1992:15).
<b>Intentional</b>	Intentional means consciousness is always consciousness of something, or, the human being is always intending a world, is a being in the world (Van den Berg 1997:204). Awareness is always an awareness of something concrete.
<b>Body-subject</b>	As a body-subject, a person and his/her body are one. Although we can objectify our bodies, that is, treat them like things to be manipulated at will, they are also our intentional selves. To describe actions that we perform unthinkingly, we must consult our acting bodies. Only we can describe these skills as accurately as we describe them (Becker 1992:18).

<b>Co-constitution of Meaning</b>	The idealists believed that knowledge resided in the thinking person. Each person discovered meaning within the mulling over knowledge until she or he arrived at its purified form. In this sense, the essence of thought was pre-given and the use of logical principles. The opposite school of thought, empiricism, purported that meaning comes from the world, that we discover it in the concreteness of existence. The empiricists believe that each person found meaning ready-made in the world and that putting oneself aside and articulating what was observable and independent of the self, out there in the world, could gain valid truths about life (Becker 1992:18). Phenomenologists also fall under these groups because if one takes the ontologic position that reality is apprehensible, then the empiricist framework becomes one's reference point (Streubert Speziale & Carpenter 2003:2).
<b>Thrownness</b>	<i>Thrownness (Geworfenheit)</i> complements the understanding of people as active subjects (Heidegger 1962 as cited in Becker 1992:21). It means that people are 'thrown into' a given world. People's cultures are well established when they enter life. As people grow up, they become active members in a life formed by factors outside their control (Becker 1992:21).
<b>Situated freedom</b>	If people are active subjects thrown into a world, how free are they? The phenomenological position, situated freedom, lies between complete freedom and complete determinism. Situated freedom means that in any given situation people can make choices. People are influenced by interpersonal, social, and biological factors, but they also appropriate these conditions. The French philosophers Jean-Paul Sartre's 1956 famous statement 'people condemned to freedom' exemplifies the phenomenological position. People must choose; even not choosing is an influential choice (Becker 1992:21).
<b>Perceptivity</b>	Along with their interest in human experience as the basis of human knowledge, phenomenologists believe that knowledge is constituted. What is known, perceived, or believed is influenced by the standpoint of the knower, perceiver, or believer. The way in which one approaches the world both opens up and limits what one finds there. All knowledge is perspectival (dependent on a specific perspective). We can deepen our insights into life by dwelling within a particular perspective. We can also enrich our understanding of life by accessing many vantage points (Becker 1992:23).

The concepts exhibited in table 1.2, are all applicable to the present study. There are, however, three concepts that set the stage for all the concepts exhibited in table 1.2. These are "being-in-the-world (embodiment)," "being-in-the-world-with-others", and "intentionality".

### 2.5.1 Being-in-the-world or (embodiment)

Being-in-the-world or embodiment is the belief that art (whatever the individual creates or constructs, whether mental or physical tangible or intangible) is constructed on the foundation of perception, or original awareness of some phenomena (Merleau-Ponti 1956 as cited in Streubert and Carpenter 1999:330). According to Van den Berg (1997:203), because human consciousness is always going beyond its material basis inside the skin, we have our being-in-the-world in the everyday, natural attitude towards the world; one simply assumes that perceived objects and the outer world are reality, with little or no self consciousness of the movements of one's consciousness to them.

As Heidegger (1969) says: *being-in-the-world is rightly ascribed to Dasein (man's existence) alone as its essential constitutive feature* (Van den Berg 1997:10). As Rice and Ezzy (1999:15) point out, the term *Dasein* was used to emphasise that people are "beings in the world." Heidegger (1962) (as cited in Becker 1992:13) as well as Rice and Ezzy (1999:16) add to this by pointing out that *Dasein* means *being there*. Heidegger (1962) emphasised that a person is always in the world. To understand people, we must understand their contexts, worlds or situations in which they live.

Applied to clinical learning, the *Dasein* of student nurses imply that student nurses are "being" (and being there) in the clinical situation. Thus, in order to understand student nurses, it is essential to understand the contexts of the clinical situations within which the student nurses exist and learn. This can only be done by first understanding the life-worlds of student nurses from their perspective and perception.

Streubert and Carpenter (1999:47) correlate being-in-the-world with Merleau-Ponti's description of embodiment. Through consciousness, one is aware of being-in-the-world and it is through the body that one gains access to this world; in addition, one feels, thinks, tastes, touches, hears, and is conscious through the opportunities the body offers. To exemplify this concept, one is reminded that as embodied beings, we are unable to completely ignore either our objective bodily existence or our subjectivity, and as such, ambiguity of our existence confronts us unceasingly (Schroeder 1991:147). Embodiment has several methodological implications. Firstly it allows for data gathering methods such as visual observation and narratives including the spoken word (interviews) and the written word (written narratives). In addition, it sets the stage for the debate on objectivity and subjectivity in both its most mundane and radical positions. The latter has further epistemological implications. These were attended to throughout the thesis.

### **2.5.2 Being-in-the-world-with-others**

Heidegger also understood people as "being-in-the-world-with-others". He saw people as networks of interpersonal relationships. Any experience of oneself and another person occurs within an interpersonal framework (Becker 1992:14).

In this regard, the student nurse is being-in-the-world (clinical learning environment), with others such as registered nurses, nurse educators, and other health workers. Any experience of a student nurse occurs within an interpersonal framework. For example, in the study conducted by Kosowski (1995:238) by being-in-the-world-with-others, student nurses uncovered the layers of their clinical experiences with patients and finally identified the “how” of learning caring. Being in-the-world-with-others also corroborates the methodological and epistemological implications indicated under being-in-the-world.

### **2.5.3 Intentionality**

As indicated by Van den Berg (1997:204) intentional means consciousness that is always directed to something or someone. The human being is always intending a world, implying that he is a being in the world. This also relates to the continuous constitution of a life-world. As Van der Wal (2005:18) indicates: “*Intentionality* is not the same as the word ‘intention’ of having ‘good intentions.’ As Watson (1999:119) indicates: “The term *intentionality*, within the mind-body field, is a more technical, philosophical term meaning ‘being directed towards a mental object’” (Watson 1999:119). At this point it should be explained that ‘mental object’ includes all human experiences and thoughts, whatever we experience we do so because we make ‘mental’ meaning and interpretation thereof. Watson continues by citing Schiltz (1996:31) who defines *intentionality* as: “Philosophically, it is consciousness about something or some content of consciousness, such as belief, volition, expectation, attention, action, and even the unconscious.” Intentionality sits at an *interface* [we emphasised] between the subject and the object (Schiltz 1996:31); the subject being the thinking mind and the object anything (tangible or intangible including norms and values) our thinking is directed at”.

Becker (1992:15) believes that for phenomenologists, intentionality is part of human nature. To live intentionally is to construct a meaningful life-world, for both self and others. Becker (1992) expands on this by citing Merleau-Ponty (1962) in stating that humans are intentional on both the reflective and pre-reflective levels of existence.

- *Reflective intentions* are those of which we are explicitly aware. We speak of these purposes readily and experience them as important contents of our lives.

- *Pre-reflective intentions* are *lived out* versus *thought about*; we express them in our actions and think about them later. Pre-reflection is done by asking the subject to describe the phenomena as fully and deeply as possible, until they have no more to say. These intentions are lived out and make us stop and look more carefully at our desires.

The epistemological and the methodological and technical implications of these different types of reflective levels, are obvious; knowledge is narrative (lingual) and the method towards eliciting information is via in-depth unstructured qualitative research interviews or so-called phenomenological interviews.

Rice and Ezzy (1999:15) affirm that the phenomenological concept of intentionality exercised an important influence on the development of qualitative research methods that examined the meanings and interpretations people give to their actions. As applied to a learning context, Klopper (1999:65) defines intentional learning as consciously taking responsibility for own learning, approaching learning in a manner of searching for meaning and controlling learning. Although based on the philosophical meaning of the word “intentionality,” Klopper’s definition embraces the more psychological meaning of this word. Intentionality offers a freedom to perceive and view things as they appear, permits them to be, and makes possible elucidation and synthesis of what appears (Moustakas 1994:81). As Van der Wal (2005:18) puts it: “(intentionality) is value neutral and has infinite potential”.

## **2.6 DIMENSIONS OF PHENOMENOLOGY**

Different authors identified different core dimensions central to phenomenology. These dimensions are summarised in table 2.3.

<b>TABLE 2.3</b> <b>DIMENSIONS OF PHENOMENOLOGICAL PHILOSOPHY</b> (After Spiegelberg 1960; Mullaney & Van den Berg 1997:158; 103; Streubert & Carpenter 1999:53)	
<b>Descriptive phenomenology</b>	Direct investigation, analysis, and description of the phenomena under study, as free as possible from preconceived expectations and presuppositions (Mullaney 1997:158)
<b>Phenomenology of essences</b>	Perception and probing of the phenomena for typical structures or essentials and for the relationship of the structures (Mullaney 1997:158).
<b>Phenomenology of appearances</b>	Giving attention to or watching for the ways phenomena appear in different perspectives or modes of clarity, that is, determined (Mullaney 1997:158).  'Reactions' produced through stimuli, which the objects emit (the out-come here is a certain agnotism/no-belief. For this standpoint, the philosopher reserves the technical term <i>phenomenalist</i> (Van den Berg 1997:103).
<b>Constitutive phenomenology</b>	<i>Constitutive Phenomenology</i> is studying the phenomenon as it becomes constituted or established in our consciousness (Mullaney 1997:158; Streubert & Carpenter 1999:53). A process in which the phenomena take shape in our consciousness, as we advance from the first impressions to a full picture of their structure (Streubert & Carpenter 1999:53).
<b>Reduction phenomenology</b>	Suspending belief in the reality or validity of the phenomena: a process that has been implicit since the inception of the method now becomes explicit through the use of the technique of 'bracketing' (Mullaney 1997:158).
<b>Interpretive or hermeneutic phenomenology</b>	Interpreting the concealed meanings in the phenomena that are not immediately revealed to direct investigation, analysis and description (Mullaney 1997:158).

Dimensions displayed in table 2.3 will be discussed with reference to their relevance to the present study.

### 2.6.1 Descriptive phenomenology

Descriptive phenomenology according to Spiegelberg (1975 cited in Streubert & Carpenter 1999:49) involves *direct exploration, analysis, and description of particular phenomena, as free as possible from unexamined presuppositions, aiming at maximum intuitive presentation*. Van den Berg (1997:108) points out that phenomenology attains a limited number of descriptive judgments that in fact possess philosophical dignity. According to Van den Berg (1997:108), the extent to which these judgments have reference to the human being as "to-be-educated" being (student nurse), they contribute to *fundamental educational theory*. Streubert and Carpenter (1999:49) further stress that descriptive phenomenology stimulates our perceptions of lived experiences while emphasising the richness, breath, and depth of these experiences.

Therefore, the following processes of descriptive phenomenology are presented.

### **2.6.1.1 Intuiting**

According to Bartjes (1991 cited in Rose et al 1995:1124), intuiting involves logical insight based on careful consideration of descriptive examples. Van den Berg (1997:204) explicitly states that intuiting is the perceptual insight into a phenomenon gained through non-conceptual experience with it. Harrison-Barbet (1990) (as quoted in Rose et al 1995:1124) points out that *intuiting* as a *technical term*, which is also referred to as *grasping*. The goal of intuiting is depicted by Knaak (1984 as cited in Rose et al 1995:1124) as the expression of the situation from the viewpoint of the subject.

In line with the abovementioned goal, Streubert and Carpenter (1999:49) advise that intuiting requires the researcher to become totally immersed in the phenomenon under investigation in order to know about the phenomenon as described by the participants. This is possible as the researcher becomes the tool for data collection and listens to the individual descriptions of the phenomenon through the interview process (Streubert & Carpenter 1999:49). For example, Neill et al (1998:16) used group interviews and individual interviews in collecting data in a study to explore the clinical experience of novice student nurses. The aim of this study was to better understand the structure and meaning of a human experience and to relate it to lived events as they are immediately experienced (Neill et al 1998:16).

Ray (1985 as cited in Rose et al 1995:1124) corroborates intuiting as a mode of awareness and processes, which involve bracketing, reduction, variation and transformation. The researcher thus avoids all criticism and evaluation and pays strict attention to the phenomenon under investigation as it is being described (Streubert & Carpenter 1999:49).

During the present study, the researcher employed phenomenological intuiting by collecting data through in-depth unstructured interviews, as well as by imposing bracketing in generating categories of data during qualitative data analysis.

### **2.6.1.2 Analysing**

The second step is explained by Streubert and Carpenter (1999:52) as *phenomenological analysing*, which involves identifying the essence of the phenomenon under investigation based on data obtained and how the data are presented. Girot (1993:114) brings forth analysing as being used to discover and understand the meaning of human life experiences through analysing the subject's descriptions of a situation. Streubert (1965, 1975 as cited in Streubert and Carpenter 1999:52) points out that the researcher distinguishes the phenomenon with regard to elements or constituents; he/she explores relationships and connections with adjacent phenomena. Streubert and Carpenter (1999:52) encourage the researcher to dwell with the data for as long as necessary to ensure a pure and accurate description. The latter aspect (dwelling) is of the utmost importance, and despite the pressure on academic results as these relate to tertiary institutional subsidy, the researcher took the time necessary to dwell with the data and to really listen to what "the data had to say".

### **2.6.1.3 Describing**

Describing is posited by Omery (1983 cited in Rose et al 1995:1125) as exploring the meaning as it unfolds for the participants and the articulations of meanings by them. Furthermore, Rose et al (1995:1125) indicates that *describing* is also known as *transforming*; the analytical process in phenomenology. Details regarding transforming data are explained in section 4.2.1.

Streubert and Carpenter (1999:52) explain that the aim of describing is to communicate and bring to written and verbal description distinct, critical elements of the phenomenon. In this regard, Rose et al (1995:1125) elaborate by citing Bartjes (1991) in stating that the transmission of experiences to written form and format may include full descriptions of cases, vignettes, and descriptions of thematic analysis. Streubert (1965, 1975 cited in Streubert & Carpenter 1999:52) warns that premature description of the phenomenon is a common methodological error. Proper phenomenological describing involves classifying all critical elements or essences that are common to the lived experience and describing these essences in detail (Streubert & Carpenter 1999:52).

During the present study, the researcher approached the data with an open mind and classified all data refining the result into critical elements, or essences that are common to lived experiences in the clinical learning environment and describing these essences in detail. Detailed information is exhibited in chapter 6.

All three descriptive processes (intuiting, analysing and describing) were applied during the present research through:

- understanding the experiences of the situation from the viewpoint of the second, third and fourth year student nurse (as an experienced learner)
- listening to the descriptions during interviews
- identifying, classifying, describing the essences in details, and analysing the descriptions by the researcher

### **2.6.2 Phenomenology of essences**

Streubert and Carpenter (1999:52) regard phenomenology of essences as involving probing through the data to search for common themes or essences and establishing patterns of relationships shared by particular phenomena. Powers and Knapp (1990) (as cited in Rose *et al* 1995:1124) articulate these with free imaginative variation, freely associating the experience with those of self and others. Streubert and Carpenter (1999:52) elaborate on this by stating that free imaginative variation, used to apprehend essential relationships between essences, involves careful study of concrete examples supplied by the participants' experiences and systematic variation of these examples in the imagination.

In this way the meaning of the phenomenon is determined (Rose *et al* 1995:1124), and it becomes possible to gain insights into the essential structures and relationships among phenomena (Streubert & Carpenter 1999:52). Probing for essences, according to Streubert and Carpenter (1999:52), provides a sense of what is essential and what is accidental in phenomenological description. Phenomenology in its descriptive stage, according to Spiegelberg (1975 cited in Streubert & Carpenter 1999:52) could stimulate one's perceptiveness for the richness of one's experience in breadth and in depth.

To determine the meaning of the factors, which influence learning in a clinical learning environment, the researcher captured vital relationships between essences, by carefully studying significant examples supplied by student nurses' experiences and systematic variation of these examples.

### **2.6.3 Phenomenology of appearances**

Van den Berg (1997:103) describes appearances as being conceived as *reactions* produced through stimuli, which the objects emit. Thus, phenomenology of appearances involves giving attention to the ways in which phenomena appear (Streubert & Carpenter 1999:53). Phenomenology is satisfied with the conviction that, that which appears to conscience is part of reality itself (Streubert & Carpenter 1999:53).

During the present study, the researcher also reflected on the relationships of phenomena. This was achieved by considering phenomena and experiences such as learning, facilitation, influencing factors, self (both participants and researcher) and the relationship between these. The researcher also distinguished the conditions under which learning is experienced or not experienced, and the nature of learning and the meaning "learning" had for the participants.

### **2.6.4 Phenomenological reduction**

Phenomenological reduction, although addressed as a separate process, occurs concurrently throughout a phenomenological investigation (Streubert & Carpenter 1999:53). To study the essence of the lived experience, as asserted by Beck (1997:409), the researcher engaged in bracketing, which acted to suspend the researcher's presuppositions about the phenomenon under study. Bracketing according to Beck (1993:167; 1997:409) is the process which involves peeling away the layers of interpretations so that the phenomena can be seen as they are, not as reflected through preconceptions. Neill et al (1998:17) view bracketing as a technique used in descriptive phenomenology to retrieve the investigator's original perceptions of the phenomenon. Moustakas (1994 as cited in Baillie 1996:1301) explains that bracketing is also called the *Epoche process*, *Epoche* being a Greek term, denoting, *to refrain from judgement*.

Neill et al (1998:17) advise that to fulfil the tenets of bracketing, investigators should discuss and set aside their personal assumptions of their own early experiences and rigorously attempt throughout the research process not to impose their clinical values on the emerging data. In terms of bracketing, Oiler's (1982 cited in Jasper 1994:311) notion is that, it is absolutely necessary to observe the experience with wide-open eyes, with knowledge, facts, and theories held at bay, and concentrating on the experience. Bracketing also needs critical self-examination of personal beliefs and an acknowledgement of understandings that the researcher has gained from experience (Streubert & Carpenter 1999:53). It is evident that bracketing does not eliminate perspectives, but it brings the experience into clear focus (Beck 1992:167).

According to Baillie (1993:1044), relevant literature should not be reviewed until data collection is completed. Postponing the literature review until data analysis is complete facilitates phenomenological reduction (Streubert & Carpenter 1999:53).

In the context of the present study, the researcher identified all the presuppositions, biases or assumptions about what influences the facilitation of learning in a clinical learning environment. Furthermore, the researcher continually addressed personal biases, assumptions, and presuppositions; and bracketed, or set aside, these beliefs about the factors, which influence learning, to obtain the purest descriptions of the phenomenon under investigation. In contrast to Baillie's (1992:1044) suggestion that the literature review should be postponed until data had been collected and analysed, the researcher, during the present research, embarked upon an in-depth literature review prior to data collection for the following reasons. The literature review:

- sensitised the researcher to the data
- improved the researcher's understanding
- improved the researcher's vocabulary in the field on research (this is of the utmost importance as English is the researcher's second language)
- enhanced the researcher's available vocabulary and language fluency which improved conceptualisation and understanding

In addition to these points, it is also argued that if personal experiences or anything else can be "bracketed" so can knowledge.

### **2.6.5 Interpretive or hermeneutic phenomenology**

According to Lincoln and Guba (1984 as cited in Streubert & Carpenter 1999:54), interpretative frameworks within phenomenology are used to research relationships and meanings that knowledge and context have for each other. This approach is essentially the interpretation of the phenomena appearing in the text or written words (Streubert & Carpenter 1999:54). One of the central arguments of hermeneutics is that the tradition of interpretation influences how a text or a set of events is understood (Rice & Ezzy 1999:24). These authors also provide critical perspectives by pointing out that positivists depict interpretation as uncertain, variable and dependent on the observer, and contrast interpretation with truth, which is certain and invariable. Rice and Ezzy (1999:26) go on to say that hermeneutics examine the circle of interpretations as lived experiences and storied interpretations continually influence each other.

According to Spielberg (1975 as cited in Streubert & Carpenter 1999:54), this is a special kind of phenomenological interpretation designed to unveil otherwise concealed meanings in the phenomena. However, Jasper (1994:48) goes further by explaining that in using the hermeneutic method, researchers seek commonalities in meanings, situations, practices, and bodily experiences in the depiction of the lived experience.

Hermeneutic methods were heralded by Rather (1992:48) by citing Heidegger (1927,1962) as methods that could be applied to one's understanding of life and other persons, the everyday world of practices, and lived experiences.

Hermeneutic phenomenology is a valuable method for the study of phenomena relevant to nursing education, research, and practice (Streubert & Carpenter 1999:54). This is evident because phenomenology was utilised in areas such as clinical instructions (Dzurec & Coleman 1997; Nehls et al 1997); student nurses' experiences (Beck 1997); the problem of rigour in qualitative research (Sandelowski 1993); and nursing as a way of thinking (Rather 1992).

With regards to the different dimensions of phenomenology, during the present study, the researcher developed consciousness through listening during interviews. In addition, the meanings of the influencing factors were identified through the conversation between participants and the researcher. Knowledge was created through

a joint project in which the participant and the researcher were jointly committed to describe the phenomenon under study. In appearance, the researcher watched the ways in which student nurses expressed themselves in describing their experiences on clinical facilitation and learning as well as paying particular attention to different factors as they influence learning. Phenomenological reduction was carried out throughout the process. The final analysis of data was accommodated by transcripts of interview data or text.

## **2.7 MOTIVATION FOR SELECTING PHENOMENOLOGY**

The following factors as outlined by Becker (1992:47), Mullaney (1997:157-159) as well as Streubert and Carpenter (1999:56), motivated the researcher to embark upon a phenomenological study pertaining to the object of interest, namely the experience of clinical learning:

- Nursing encourages detailed attention to the care of people as humans and grounds its practice in a holistic belief system that cares for mind, body, and spirit (Streubert & Carpenter 1999:56). Therefore, Drew (1989 cited by Mullaney 1997:159) advises that if one is serious about humanising health care and making holistic care available to clients, it is important to expand the research methods to fit this holistic task. The holistic approach to nursing is rooted in the nursing experience and is not imposed artificially from without (Streubert & Carpenter 1999:56). In an attempt to reflect congruence in the philosophical and worldview, nursing education is conducted from the same perspective as nursing practice. What goes for phenomenology and nursing practice thus also holds for nursing education.
- Becker (1992:47) is of the opinion that the structural understanding of what something is for the people experiencing it, can provide crucial information in theoretical, empirical, and intervention realms. Streubert and Carpenter (1999:56) advocate this by indicating that for the reason that phenomenological inquiry requires that the integrated whole be explored, it is a suitable method for the investigation of phenomena important to nursing practice, education, and administration.
- According to Becker (1992:47), the benefit of phenomenological research resides in providing an understanding of phenomena as they are lived by people in the

everyday world. Shared lived experience should be the best data source for the phenomenon under investigation (Streubert & Carpenter 1999:56).

- As Becker (1992:48) points out, the product of phenomenological research, descriptive portraits of phenomena's essential structures and experiential components, give a view on topics situated within the real lives of whole people, (individuals as a whole). Streubert and Carpenter (1999:56) corroborate this by asserting that because the primary source of data collection is the voice of the people, experiencing a particular phenomenon, the researcher should determine that this approach would provide the richest and most descriptive data.
- Becker (1992:48) is of the opinion that as empirical phenomenological investigations result in descriptive summaries of what something, including an experience, is, they evoke within the reader similar and different experiences of the phenomenon; and, through this resonance, convey validity of the findings. The possibility of constructing a written interpretation of human experience also makes possible an interpretation of that experience by anyone reading it (Mullaney 1997:157).
- Phenomenological research uncovers rich sources of insight into human life (Becker 1992:48). Nurses who want to increase their understanding of a given lived experience can use the phenomenological method to gain that understanding within their everyday practice (Mullaney 1997:159) as well as everyday practice such as clinical learning.

In addition to the above, phenomenology is presently prevalent in nursing research, literature and theory construction and development as well as in nursing practice, education and management.

Parse (1985 as cited in Jasper 1994:313) indicates that nursing theories recognise the fundamental individualistic and unique nature of human beings that directs their behaviour, with the humanistic values and beliefs of phenomenology. Phenomenology provides nursing with a method, which focuses on the clients' experiences of care they receive, which in turn can be used to plan for future care (Jasper 1994:313). Theories falling within this cadre include the work of Travelbee (1971), Paterson and Zderad (1976), and the caring theories (Watson 1979), Parse (1981) as well as Boykin and Schoenhofer (1993). The educational domain of nursing lends itself to qualitative

investigation in areas such as assessment of competence in a clinical learning environment (Girod 1993), and factors affecting student nurses (Baillie 1993).

Several other researchers have used phenomenology as qualitative method to investigate phenomena unique to nursing education. Some examples of these include, an overview and critique of the study 'nursing students' experiencing caring for dying patients' by Beck (1997); the preceptor model of instruction: the lived experiences of students, preceptors, and faculty-of-record (Nehls et al 1997); the clinical experience of the novice students in nursing (Neill et al 1998); and the maintenance of caring by the care giver (Van der Wal 1999).

In addition, phenomenology has also a value in nursing in its direct applicability in nursing practice. For instance, phenomenology as a qualitative research method has been used to explore a variety of practice-related experiences such as postpartum depression (Beck 1992); and a phenomenological study of the nature of empathy conducted by Baillie (1996).

The relevance of phenomenology as a research method for nursing is clear. Within the qualitative paradigm, this method supports 'new initiatives for nursing care where the subject matter is often not amenable to other investigative and experimental methods (Jasper 1994:313). Phenomena related to nursing can be explored and analysed by phenomenological methods that have as their goal, the description of lived experience (Streubert & Carpenter 1999:62).

## **2.8 PHENOMENOLOGY AND QUALITATIVE RESEARCH**

Phenomenology is viewed by Merleau-Ponti (1962 as cited in Beck 1997:409) as a qualitative research design, which is an inductive, descriptive research method that studies essences. Qualitative studies share a number of similarities in terms of overall goals and techniques, but there are actually a variety of theoretical and philosophical traditions that fall within the broad umbrella of qualitative research (Polit & Hungler 1993:32). As Rice and Ezzy (1999:14) indicate, the European phenomenology of Edmund Husserl (1859-1938), Alfred Schutz (1899-1959), and Martin Heidegger (1889-1976), forms the philosophical background to many of the more familiar theories and methods in qualitative research. Contemporary qualitative research also includes as a

philosophical and meta-theoretical baseline, humanism and existentialism and humanistic-existentialism as implemented in the Duquesne tradition by Von Eckartsberg (1983), symbolic-interactionism (grounded theory), post modernism and the like. The implementation of phenomenology within the qualitative research paradigm is discussed in detail in chapter 4 explaining the research design adopted to conduct this study.

## **2.9 CONCLUSION**

Phenomenology is a fundamental field of inquiry to nursing. Phenomenology aimed at articulating human experiences into language. Husserl, Kierkegaard, Heidegger, Merleau-Ponti and others influenced the phenomenological movement. Concepts central to the method include embodiment or being-in-the-world, intentionality, essences, intuiting, reduction, and bracketing. Six core steps or elements central to phenomenological investigation include: descriptive, essences, appearances, constitution, reduction, and interpretation. The current phenomenological study also provided précised reflection to matters concerning the researcher as an instrument, selection of subjects, data collection and recording and considering an issue of rigour. Phenomenology can thus, be used and applied to the present study.

Chapter 3 presents a preliminary literature review about the student nurses' lived experiences of clinical facilitation in the clinical learning environment.

## Chapter 3

### Preliminary literature review

#### 3.1 INTRODUCTION

A literature review is a systematic search of published works to gain information about a research topic (Polit & Hungler 1995:69; Talbot 1995:114). The primary rationale for reviewing literature relevant to this study is to gain a background understanding of the information available on the lived experiences of student nurses in the clinical learning environment. The reader should thus see this preliminary literature review as an extension of the background to the present research.

During the present study, the researcher pertinently reviewed literature prior to data collection and analysis, to relate the study to what others have done. Taylor and Bogdan (1984:135) assert that other studies often bring in fruitful concepts and propositions that will help the researcher interpret his or her data. In addition, reviewing relevant literature assists in identifying the range of past research studies, summarising the present state of knowledge, differentiating between commentary and research, or identifying the theoretical base of knowledge and assisting the researcher to gain new insights into new methods that may be used (Clifford 1997:161; Polit & Hungler 1995:70).

Van der Wal (1999:90) highlights that the first moment of the research is a preliminary identification of the phenomenon in the light of the research of interest. This is considered by Wertz (1984:33) as the researcher's entry point into the research process, which delivers him/her to a circumscribed area of existence. As Colaizzi (1973:28) views it: *without first disclosing the foundations of the phenomenon, no progress whatsoever can be made concerning it, not even a first faltering step can be taken towards it, by science or by any other kind of cognition.*

In the light of the above, the researcher reviewed literature prior to data collection, although most researchers and authors in qualitative research conduct a literature review after their data have been analysed (Baillie 1993:1044; Streubert & Carpenter 1999:53). Therefore, the researcher engaged in bracketing by examining the experiences in the clinical learning environment as they arise from the descriptions of

participants rather than the researcher's preconceptions. During the reduction process the researcher remained faithful to the words and meanings as described by participants themselves. The reduction process was explained earlier in chapter 2, section 2.6.4.

### **3.2 GUIDING FRAMEWORK FOR LITERATURE REVIEW**

The literature review was conducted to critically evaluate the current level of available knowledge. This involved locating, critically evaluating and summarising existing information on student nurses' lived experiences in the clinical learning environment. The researcher conducted the literature search using computer facilities available at the UNISA library as well as identifying potentially useful articles by consulting the reference lists of the articles that were obtained from the library subject specialist.

Having collected; critically analysed; and categorised a large body of literature concerning lived experiences of student nurses, helped in establishing conceptual clarity. A comprehensive review of information also led to incorporating other aspects related to the study. Conceptual clarity served the purpose of bringing into mind what the researcher already knew, so as to evaluate the researcher's interpretation of data for trustworthiness.

The current researcher's query was about the student nurses' lived experiences of the clinical learning environment and raised the following question:

*What is the lived experience of student nurses in the clinical field as earning field?*

The subject matter that emanated from the literature search, which provided evidence of applicability to the current study is displayed in table 3.1.

TABLE 3.1 SUBJECT MATTER THAT EMANATED FROM THE LITERATURE SEARCH		
DESCRIPTION OF THE NATURE OF THE CLINICAL LEARNING ENVIRONMENTS	FACTORS PROMOTING CLINICAL LEARNING	EROSIVE FACTORS OF LEARNING IN THE DOMAIN OF CLINICAL FACILITATION
<p><b>Clinical learning environment</b>  <b>Attributes of clinical learning environment</b></p> <ul style="list-style-type: none"> <li>• Autonomy and recognition</li> <li>• Job satisfaction</li> <li>• Role clarity</li> <li>• Quality of supervision</li> <li>• Peer support</li> <li>• Opportunity for learning</li> </ul> <p><b>Clinical learning experiences</b></p> <ul style="list-style-type: none"> <li>• Meaning of clinical learning experiences</li> <li>• South African Nursing Council (SANC) requirements for clinical learning experiences</li> </ul> <p><b>Benefits of clinical learning experiences</b></p> <ul style="list-style-type: none"> <li>• Student nurses are challenged to try new modalities</li> <li>• Tolerance of ambiguities</li> <li>• Professional socialisation</li> <li>• Develop competency</li> </ul> <p><b>Didactic approaches used to enhance from clinical learning experiences and opportunities</b></p> <ul style="list-style-type: none"> <li>• Enhancing critical thinking skills</li> <li>• Employment of quality assurance practices</li> <li>• Coaching as an interactive process</li> </ul>	<p><b>Factors related to student nurses</b></p> <ul style="list-style-type: none"> <li>• Prior knowledge and experience</li> <li>• Student nurses' attitude to learning</li> <li>• Student nurses' being active and self directed</li> <li>• Knowing the patient</li> </ul> <p><b>Factors related to the clinical facilitator</b></p> <ul style="list-style-type: none"> <li>• Personal attributes of clinical facilitator</li> <li>• Professional knowledge and skills</li> <li>• Presence of the facilitator/ teacher</li> </ul>	<ul style="list-style-type: none"> <li>• Poor student-facilitator relationships</li> <li>• Unfamiliar environments, stress and anxiety</li> <li>• Gender and age related issues as an erosive factors</li> <li>• Shortage of resources</li> <li>• Facilitators and knowledge</li> <li>• Student nurses not meeting their defined role criteria</li> </ul>

The researcher discusses these aspects (mentioned in table 3.1) in the following section.

### **3.3 DESCRIPTION OF THE NATURE OF CLINICAL LEARNING ENVIRONMENTS**

The description of the nature of clinical learning environments is detailed in the following sections.

#### **3.3.1 Clinical learning environment**

The *clinical learning environment* is the environment in which student nurses perform skills related to the needs of patients and provide physical, psychological, spiritual and social support utilising a holistic approach, in order to promote and maintain safe, effective patient care (Carlson et al 2003:32). An interactive network of forces within the clinical learning environment influence student nurses' clinical learning outcomes (Dunn & Burnett 1995:1166). These forces could include the setting and faculty, availability of clients, nurses and material resources.

#### **3.3.2 Attributes of clinical learning environment**

Dunn and Burnett (1995:1166) are of the opinion that the identification of factors that characterise the clinical learning environment could lead to strategies that advance those factors most predictive of desirable student learning outcomes and ameliorate those which may have a negative impact on the student nurses' learning outcomes. Consequently, the researcher identified and discussed attributes of a learning environment as uncovered from published reviewed literature.

##### **3.3.2.1 *Autonomy and recognition***

Autonomy and recognition refer to the degree to which nurses (including student nurses in the clinical field) are valued, acknowledged and encouraged to take responsibility for their own practice (Hart & Rotem 1995:6). In this regard, Hart and Rotem (1994:28) point out that in the clinical learning environment, it is important that student nurses should show initiative and act at appropriate levels of autonomy. A study by Wilson (1994:85) substantiates this as student nurses experienced that while they were in the clinical learning environment, their role was more important, in the sense that it had an impact on their willingness to structure their clinical learning experiences in ways that were not threatening to the traditional student nurses' role. This is further corroborated

by Gray and Smith (2000:1546) who articulate autonomy and recognition with being given a sense of responsibility to perform activities without being instructed, trusting student nurses to perform such activities by themselves.

The importance of autonomy and recognition of student nurses in the clinical field is further sustained as society expects nurses to be autonomous in their thinking and their achievements, to be able to adapt swiftly and creatively to changes in their environments, and to work hard towards self-actualisation (Dumas et al 2000:252). Concurringly, Tanner (2002:52) advises that student nurses need experiences to render their care like nurses.

Therefore, willingness to structure one's own clinical learning experiences upon being given a sense of responsibility as a student nurse, reflects a preparedness to embrace ones' personal and professional autonomy. If a student nurse has autonomy and recognition, and an awareness of responsibility and accountability result from this, then the student nurse is more likely to generate self-initiated learning within the clinical learning environment.

### **3.3.2.2 *Job satisfaction***

Job satisfaction refers to the level to which student nurses enjoy their work and intend to pursue a career in nursing (Hart & Rotem 1995:6). Job satisfaction could be articulated with the student nurses' ability to recognise their own value within the work environment. To substantiate this statement, Dumas et al (2000:251) argue that the ability of student nurses to recognise the value of their experiences as a starting point for their professional development, allows them to remain above the wave of change in their day-to-day professional world, provided that they know how to learn from it. If the latter occurs it can be alleged that student nurses are experiencing job satisfaction in which instance learning is likely to result.

### **3.3.2.3 *Role clarity***

According to Hart and Rotem (1995:6), role clarity refers to the extent to which staff understand and accept their role and responsibilities. This is also attained through experiencing and understanding oneself. According to Becker (1992:14), any

experience of self (and others) occurs within an interpersonal framework. As Carlson *et al* (2003:36), indicate, this aspect of the student nurses' lived experience during clinical placement is often ignored. These authors found that there was a lack of awareness amongst senior professionals of the needs and problems of first year student nurses in the wards. These professional nurses also verbalised that everyone assumed that student nurses knew what to do. This could have grave implications for student nurses' perceptions of, and definitions of, their roles in the clinical arena. To overcome the problem of student nurses' not clearly perceiving their role in the clinical area, Edmond (2001:257) suggests the Canadian model in which each speciality unit has a resident clinical teacher who had been appointed from senior staff nurses. This unit clinical teacher's prime responsibility is to work alongside all newcomers to the unit, including student nurses, to assist in clarifying their roles experientially.

#### **3.3.2.4 Quality of supervision**

Hart and Rotem (1995:6) define quality supervision as the degree to which supervision and staff interaction facilitates or impedes practices. Tanner (2002:51) asserts that increasing acuity in most settings terrifies beginning student nurses and raises the spectre of unaffordable student-faculty ratios to assure safe levels of supervision. In Carlson *et al*'s (2003:38) study, student nurses pointed out that because they were new to a unit, they needed somebody to 'check' them whilst rendering patient care and practising skills. Bezuidenhout (2003:19) asserts that nurse training relies heavily on both theoretical class teaching and clinical application of knowledge. The integration of theory and practice is essential in ensuring successful learning outcomes. Participants in Bezuidenhout's (2003) study, accordingly, emphasised the value of clinical supervision for enhancing the correlation of theory and practice.

#### **3.3.2.5 Peer support**

Hart and Rotem (1995:6) define peer support as the extent to which, members of staff are friendly, caring and supportive towards one another. Byrd *et al* (1997:351) emphasise effective communication between registered nurses and student nurses to enhance clinical learning. A study conducted by Neill *et al* (1998) revealed that sophomore student nurses relied on mentors such as instructors, staff nurses, nursing assistants, who helped them learn what they needed to do in order to *fit in*. Pollard and

Hibbert (2004:40) also, found during discussions with the senior nurses, that it was essential to support the increasing numbers of student nurses. An environment characterised by peer support assists student nurses to realise learning opportunities and consequently gain learning experiences.

### **3.3.2.6 Opportunity for learning**

Opportunities for learning refer to the range and diversity of events in the clinical learning environment which could contribute towards the student nurses' professional socialisation (Hart & Rotem 1995:7). In a study conducted by Little (2000:393), student nurses pointed out how they were inclined to make use of learning opportunities when colleagues were supportive of their student nurse role. In the study conducted by Gray and Smith (2000:1545) regarding the qualities of an effective mentor, it was found that student nurses rapidly learned to take advantage of learning opportunities as they arise in appreciation of their mentors' efforts to offer quality time to their learning. According to Pollard and Hibbert (2004:41) too, development of learning opportunities, which incorporate the patient's experiences on and off the ward, seems important for enhancing student nurses' learning.

In conclusion then, a major quest in clinical learning and teaching is to guide student nurses towards identifying and utilising available learning opportunities in the clinical learning environment.

### **3.3.2.7 Integration**

The attributes of the clinical learning environment could promote or hinder clinical learning, depending on their innate quality at any point in time. With regard to these attributes, Fothergill-Bourbonnais and Higuchi (1995:39) point out that for maximum effectiveness, a learning environment which correlates with the level of student or curriculum goals should be selected. These researchers state that there are learning environments that are best suited for senior student nurses. Such examples could refer to patient care that requires that student nurses cope with sudden and unexpected changes in patients' status. In addition, Klopper (1999:26) advises that the learning environment should be created in such a way that student nurses would *want* to learn. These attributes should be utilised towards this motivational end.

The components of an evidence-based environment as outlined by Erickson-Owens and Kennedy (2001:143) also correlate with the motivational attributes mentioned by Hart and Rotem (1994:28). These components of the evidence-based environment include

- easy access to current and relevant research
- appropriate user-friendly equipment
- available trained staff utility
- supported evidence-based care (EBC)

One can thus argue that it is in fact the *evidence* of evidence-based nursing care that forms the crux of learning opportunities in the clinical field.

The preliminary literature review on attributes as motivational factors in the clinical learning environment served to identify pointers indicating the inclusion (and exclusion) criteria in sampling the sites in which the present research was conducted. In addition, being acquainted with the purpose of placing student nurses in specific clinical areas further illuminated the inclusion and exclusion criteria for the selection of research sites. The sampling technique involved in this is discussed in section 4.3.2.

### **3.3.3 Clinical learning experiences**

Literature reviewed about student nurses' clinical learning experiences pertained to the SANC's requirements for clinical learning experiences and to the meaning of these experiences.

#### **3.3.3.1 *Meaning of clinical learning experiences***

The present study focuses on the experiences of student nurses enrolled under the comprehensive programme for the education and training of a nurse (general, psychiatric, and community) and midwife leading to registration according to R425 of 1985, as amended (hereafter referred to as the four year comprehensive programme or merely Regulation R425).

According to Boeree (1998:6), the literature on meaningful learning focuses on the positive feeling of the *aha* experience, at the same time as one thinks it is the solution and its pleasure constitute the meaningful learning experience. Reilly and Oermann (1992:348) assert that experiences in the clinical learning environment provide for the development of the learner in terms of knowledge, skills, and values inherent in the profession's practice. White and Ewan (1991:161) are of the opinion that quality of the clinical experience depends on widening student nurses' capacities to take on new experiences and to grasp the meaning each experience has for them in the present, and how it will prepare them for the future experiences.

Preparing student nurses for the future corresponds to professional socialisation of a student nurse as discussed in section 3.3.4.3.

### **3.3.3.2 South African Nursing Council (SANC) requirements for clinical learning experiences**

To enable student nurses to gain clinical learning experiences, SANC (1985) stipulates the subject curriculum of the four-year comprehensive programme (Regulation R425), which includes the expected hours for exposure within the clinical learning environment.

The subject curriculum outlined in Regulation R425 guides facilitators within the clinical learning environment with regard to clinical experiences students should be involved in, based on the level of advancement of the student nurse. The understanding of SANC's requirements in terms of the expected hours of clinical learning is important not only to enable colleges to draw up their clinical allocation programmes, but also to provide a clear guideline to both student nurses and those involved in clinical facilitation regarding the clinical learning experiences relevant to the level of advancement of student nurses. The SANC's stipulations regarding the expected clinical hours are reflected in table 3.2.

<b>TABLE 3.2 SUBJECT CURRICULUM STIPULATED BY THE SANC</b>		
<b>SUBJECT</b>	<b>ACADEMIC YEARS</b>	<b>CLINICAL HOURS</b>
Fundamental nursing science, ethos of nursing and professional practice	3 academic years	
General nursing science	2 academic years with at least	72 hours
Psychiatric nursing sciences	2 academic years with at least	800hours
Midwifery	2 academic years with at least	800 hours
Community nursing sciences	2 academic years with at least	320 hours
Biological and natural sciences	2 academic years	
Pharmacology	½ academic year.	
Social sciences	2 academic years.	

The reader is advised to read the contents of table 3.2 in conjunction with the background to the allocation of student nurses in the LP outlined in section 1.2.4.2, as well as the section 4.3.2 on the research design which outlines the characteristics of the participants included in the study.

The stipulations from R425 (SANC 1985) regarding the clinical hours for student nurses, are in accordance with the stipulations of the Basic Condition of Employment Act (Act 75 of 1999) (BCEA) of South Africa. The requirements from this Act include that all employees should spend 9 hours per day and 40 hours per week on duty. The Act does not exclude student nurses within the clinical learning environment and complying with these stipulations socialises a student nurse towards later professional adherence with these stipulations. This point of articulation between the stipulations of the Basic Condition of Employment Act, and R425 (SANC 1985), was taken seriously during the present study. Student nurses are expected to be present in the clinical area as stipulated; a presence that is defined by interaction and connection during clinical learning placements. Understanding the way in which interaction and connection figure during the prescribed clinical placement hours, could lead to an understanding of the experience of student nurses in the clinical learning environment.

### **3.3.4 Benefits of clinical learning experiences**

There are numerous potential benefits of clinical learning experiences including being challenged by new modalities, tolerating ambiguities, socialising professionally, developing competency and integrating lived experiences in the clinical environment.

#### **3.3.4.1 Student nurses are challenged to try new modalities**

According to Reilly and Oermann (1992:6), the clinical learning environment provides a fertile experience in learning how to learn. These authors believe that multidisciplinary encounters in clinical learning environments expose student nurses to different approaches to similar problems. Furthermore, the clinical learning environment presents student nurses with unique problems they will encounter when they qualify as registered nurses (Laschinger 1992:112; Naude, Meyer and Van Niekerk 1999:108).

In addition, Dunn and Burnett (1995:1166) are of the opinion that a thoughtful and well-informed development of clinical learning environments could enhance student nurses' learning opportunities and facilitate the achievement of optimum learning outcomes. According to Massarweh (1999:44), the clinical learning environment provides an opportunity to apply theory to practice and fosters problem-solving skills. Therefore, student nurses could only acquire clinical learning experiences from the learning opportunities available within the clinical learning environments.

#### **3.3.4.2 Tolerance of ambiguities**

Taylor (2000:173) defines ambiguity as a natural condition of life, which indicates lack of clarity in situations. Furthermore, this author clearly distinguishes between tolerance and intolerance of ambiguity. Tolerance of ambiguities is referred to as the tendency to perceive or interpret ambiguous situations as desirable while intolerance of ambiguities as the tendency to perceive ambiguous situations as threats (Taylor 2000:173).

As Taylor (2000) points out, an ambiguous situation is one that lacks sufficient cues; referred to, by Reilly and Oermann (1992:7) as *uncertainty*. In the clinical learning environment, professional curricula are often limited in helping student nurses develop a practice modality, which provides for competencies in addressing the uncertainties of

clinical reality (Reilly & Oermann 1992:7). According to Nahas (1998:664), the unpredictability of the clinical environment could be a very stressful experience for student nurses. Nahas et al (1999:639) further point out similar concerns by indicating that the unpredictable clinical learning environment could affect the clinical teachers' control over the learning experiences of student nurses.

Either a clinical teacher, or any one involved in clinical facilitation, could be equally affected by unpredictability of the clinical learning environment. Important in this regard is that the clinical facilitator caught off guard is as much a clinical learning opportunity as is the actual clinical happening. In this regard Dyson's (2000:20) opinion that facilitators are required to be visible in the clinical learning environments as they encourage positive attitudes for the clinical staff and create a positive learning environment for student nurses, amidst the ambiguities encountered, should be taken seriously by facilitators. In addition, involving student nurses in discussing specific ambiguous situations encountered, over and above strategies used effectively to address these ambiguities, could help other student nurses to develop both a more realistic view of health care and a sense of empowerment in addressing ambiguities (Taylor 2000:174).

An overall purpose of clinical placement is thus to acquaint the student nurse with the ambiguities and uncertainties of the clinical learning environments and to prepare them to manage such ambiguities and uncertainties.

### **3.3.4.3 Professional socialisation**

A further purpose of clinical learning experience in an educational programme is to enhance professional socialisation of student nurses. Scambler (1991:222) defines professional socialisation as a process by which members of the lay population are turned into members of a particular professional population. According to Ewan and White (1991:160), the clinical learning environment is a fertile ground for personal growth and professional socialisation. The clinical learning environment enables student nurses to develop the process of thinking most appropriate to the profession (Reilly & Oermann 1992:8).

The practice component of a professional programme contributes significantly to the socialisation of the student nurse into a professional role and its concomitant values of

social consciousness, ethical and moral accountability, and responsibility to the society (Reilly & Oermann 1992:9). Additionally, the clinical learning environment assists student nurses to collaborate with others and to develop legal and ethical sensitivity (Massarweh 1999:44). According to Pollard and Hibbert's (2004:43), participants' clinical placements were important to them as student nurses, to socialise them into the ward environments; learning the ward routine so that they could undertake core-nursing tasks.

#### **3.3.4.4 The development of competency**

Most activities are performed effectively through deploying skills, knowledge and behaviours (or attitudes) in combination. Different types of competencies can define each of these facets of performance. For example, definitions of the skills and knowledge types of competency are often called technical, functional, "hard" or job-related competences, and being concerned with customer care is a behavioural competency. According to Whiddett and Hollyforde (2003 as cited in *Encyclopaedia* 2005), the definition of competency is based on behaviour observed within the organisation setting. This definition includes the fact that competencies are behaviours that individuals demonstrate when undertaking job-relevant tasks effectively within a given organisational context. *Encyclopaedia* (2005) also cites Byham (1996); Kevin and Bernthal (1998) through mentioning that the word 'competencies' is used in many contexts, with very different meanings. Basically, competencies fall into three categories or types:

- first, organisational competencies such as unique factors that make an organisation competitive
- second, job/role competencies for instance, things an individual must demonstrate to be effective in a job, role, function, task, or duty, an organisational level, or in the entire organisation
- third, personal competencies, in the same way as aspects of an individual that imply a level of skill, achievement, or output." The third category is therefore related to the current study (*Encyclopaedia* 2005).

Girot (1993:115) gives Benner's (1982) explanation of competence in nursing as the real world of practice which consists of conscious, deliberate planning, where the nurse

sets priorities and is efficient and effective in routine situations. Competence is also developmental in nature, ranging from novice to expert as demonstrated in table 3.3.

<b>TABLE 3.3</b>		
<b>DREYFUS MODEL OF SKILL ACQUISITION AND DEVELOPMENT</b>		
<b>(Benner 1984 as cited in Reilly &amp; Oermann 1992:225; Evans 2000:134)</b>		
<b>STAGE</b>	<b>LEVEL</b>	<b>KNOWLEDGE AND EXPERIENCE</b>
<b>Stage 1:</b>	Novice	Lacks practical knowledge and skill focus on individual pieces of information
<b>Stage 2:</b>	Advanced	Have enough clinical experience to identify meaningful characteristics, referred to clinical situation.
<b>Stage 3:</b>	Competent	Ability to plan in a conscious way Plan reflects long-term goal Two years experience in clinical situation
<b>Stage 4</b>	Proficient	View the clinical situation in terms of gestalt rather than specific aspects within it

Clinical learning enables a student nurse to develop competency to a designated level under the supervision of a faculty member or a preceptor (Reilly & Oermann 1992:10).

Laschinger (1992:113) points out that the impact of different nursing learning environments on competency development seems consistent with theoretical expectations and supports the notion that a variety of environments contribute to the development of different types of competencies. In addition Benner (1984) (as cited in Evans 2000:134) puts forward that the novice applies rules without regard to context and flexibility, while at a slightly more mature level, an advanced beginner starts to perceive meaningful patterns in practice but is unable to set priorities. According to Benner (1984:405), a proficient learner is expected to perceive situations in totality. Chabeli and Muller (2004:74) corroborate this by stating that at the proficient level, learners should be taught by using strategies in which their ability to grasp the situation is solicited and taxed.

Each of the abovementioned levels of competency is influenced by what the student nurse experiences within the clinical learning environment.

#### **3.3.4.5 Integration**

The benefits of clinical learning environments are closely related. Ultimately these benefits contribute towards student nurses' professional socialisation and competence in managing ambiguous situations. In this regard the present study sought to uncover student nurses' lived experiences in the clinical environment as learning environment in

an attempt to establish whether personal experiences and perceptions of the clinical field in promote or hamper professional socialisation.

### **3.3.5 Didactic approaches used to enhance from clinical learning experiences and opportunities**

Although many different teaching and didactic strategies might be employed in clinical teaching, such as discussions, utilisation of the teachable moment, values clarification sessions, seminars and ward rounds, this section focuses on broader didactic approaches employed to enhance clinical learning.

#### **3.3.5.1 *Enhancing critical thinking skills***

Jenkins and Turick-Gibson (1999:11) define critical thinking as reasonable reflective thinking that is focused on deciding what to believe or do. Massarweh (1999:45) sees critical thinking as involving inquiry, open-mindedness, reasoning, and analysis of data. Atkins and Murphy (1993:1188) see the outcome of reflection as learning. In a study by Chabeli and Muller (2004:62), participants realised the important role played by knowledge acquisition in a specific situation as the building block on which reflective thinking is based. The relationship between the critical thinking skills, reflective practice and learning of student nurses during clinical facilitation in the clinical environment is that when the student nurse and the clinical facilitator exchange ideas and descriptions, processes of reflection and critical thinking connect. During the connection of these two processes learning results.

At this point in the present study, critical thinking and reflective practice have more methodological and epistemological implications than ontological implications. The fact that critical thinking skills to a large extent relate to professional socialisation has implications for the data collected. Putting it differently, the degree to which the individual participants are able to reflect on practice and experiences and are involved in reflective practice will greatly influence their accounts of lived experience and the way in which they involve themselves in the clinical learning situation.

### 3.3.5.2 Employment of quality assurance practices

Quality assurance refers to the process of establishing desirable standards of nursing care, planning and providing the type of care that will meet these standards (Naude et al 1999:253).

According to McLaughlin and Kaluzny (2004:10), quality has been, and continues to be, a central issue in a health care organisation (clinical environment) and among health care providers including clinical facilitators and student nurses. Closely related to quality assurance practices in relation to the experiences of student nurses in the clinical environment, are issues surrounding total quality management. Katz and Green (1997:10) define quality management as the process by which people are mobilised to achieve quality goal. Massarweh (1999:46) expands on the definition through stating that in total quality management student nurses can learn through management principles such as management accountability, teamwork, continuous improvements that focus on work processes, customer orientation, and statistical analysis.

Total quality management principles serve as a framework for clinical teaching and thus clinical learning in the setting, providing structure to encourage student nurses to work together (Massarweh 1999:47). The directorate for quality assurance within the National Department of Health (2001:45, par 11) supports this by explicitly stating in its policy on quality in health care for Southern Africa that a health care organisation dedicated to continuous improvement must become by definition, a learning organisation. This is also a foundational assumption for the present research. The policy furthermore, defines the learning organisation as an organisation which is skilled at creating, acquiring, and transferring knowledge and at modifying its behaviour to reflect new knowledge and insights.

According to the National Department of Health in South Africa (2001:46) what could be learned through the employment of quality assurance practices in the clinical learning environment during clinical facilitation include:

- understanding a system for instance, clinical environmental vision, mission and plans
- using information

- committing to evidence-based health care

The notion of quality assurance within clinical learning environments also finds support from other countries. For example, the Department of Health (1999) in the United Kingdom, highlighted the variations in clinical learning experiences for student nurses and called for improvements in this area such as the promotion of consistency and quality in all placement areas (Pollard & Hibbert 2004:40).

It is thus apparent that there is a relationship between quality assurance and the resulting quality on the one hand, and the experiences of student nurses' learning in the clinical learning environment on the other hand. This relationship is reciprocal; existing quality care provides quality learning experiences and quality learning in turn lead to student nurses rendering quality care based on the quality knowledge and skill they have acquired; a positive upward learning spiral. Again, the actual setting in which the participants find themselves in this regard would greatly influence their perceptions and experiences, again serving as a source for variation and richness in the data collected.

### **3.3.5.3 *Coaching as an interactive process***

Coaching is described by Morton-Cooper and Palmer (1993:47) as an interactive, interpersonal process that involves the acquisition of appropriate skills, actions, and abilities that form the basis of professional practice. According to Grealish (2000:231), the coach is described as someone who assists the student nurse with personal progress during clinical placements and provides a safe environment for learning.

If a student nurse experiences such assistance with personal progress, he/she could obtain a better understanding of reality in the clinical learning environment and also, a foundation from which to operate as the student nurse such as interacting with the world (clinical learning environment). Grealish (2000:231) further elaborates on the definition by stating that coaching is in a one-to-one relationship. One can, however, view the one-to-one relationship between a student nurse and the clinical facilitator as an outcome of social learning within the clinical environment.

Dumas et al (2000:251) hold similar beliefs in relation to student nurses' learning within the clinical learning environment through referring to coaching as an antecedent of learning. Dumas et al's (2000) beliefs include the fact that when student nurses realise their own experiential learning patterns, they can be coached on how to learn from it for future experiences.

Based on the above-mentioned statements, the student nurse who is being coached, during the interaction process, could experience what could be created through sharing the experiences between the student nurse and the clinical facilitator within the clinical learning environment.

### **3.4 FACTORS PROMOTING CLINICAL LEARNING**

As indicated previously, part of the reason for having conducted a preliminary literature review on the research topic prior to conducting the research was to sensitise the researcher to the field of study. Factors promoting learning in the clinical field emerged from the data as the field of interest that could have definite influences on student nurses' experience in the clinical field and their perception of learning in the clinical field. These include factors relating to student nurses and factors relating to clinical facilitators (including all clinical staff in relation to their professional responsibility to contribute towards the professional development and socialisation of nascent professionals).

#### **3.4.1 Factors relating to student nurses**

Factors relating to student nurses include prior knowledge and experience, student nurses' attitudes to learning, student nurses being active and self-directed as well as knowing the patient.

##### **3.4.1.1 *Prior knowledge and experience***

According to Baillie (1993:1045), previous experience could influence student nurses' learning positively or negatively, depending on the individual concerned, and the type of experience already gained. In this regard Fothergill-Bourbonnais and Higuchi (1995:38), state that opportunities that encourage student nurses to build on and apply previous knowledge should be provided in the clinical learning environment. Neill et al (1998:20)

draw attention to the fact that faculty, which acknowledges cognitive developmental levels of their student nurses are able to select and plan optimum clinical learning opportunities for those student nurses.

Again, the level and nature of previous experiences and knowledge acquired by participant will have an effect on participants' experience and perception of the clinical field as learning field. The ratio between positive and negative experience participants have had might have influenced their participation and involvement in the clinical and situation and consequently the accounts regarding their lived experience in the clinical field.

### ***3.4.1.2 Student nurses' attitudes to learning***

Student nurses' attitudes to learning in the clinical field and their placement in certain clinical fields may be largely influenced by previous experiences and knowledge gained as well as by notice taken of others' experiences in these fields. According to Baillie (1993:1046), most student nurses recognised their attitudes to placements in different clinical environments and that these attitudes affected their learning while in these areas. In Baillie's (1993) study, student nurses commented that it was important for them to show an interest in and take initiative of, as well as having positive attitudes towards learning if they were to gain anything positive from these placements and experiences.

### ***3.4.1.3 Student nurses' being active and self-directed***

According to Erickson-Owens and Kennedy (2001:143), student nurses in the clinical learning environment should be active, committed, curious, self-directed, and responsible. In this regard Baillie (1993:1047) found that student nurses explicitly experienced active participation during their placements as positive and gratifying occurrences, which promoted learning. In a study conducted by Perry (2000:143), active involvement (and gratification) of student nurses figured in:

- Tacit knowledge that embraces knowing-in-action and depends on a repertoire of experiences built up over time, such that practice becomes repetitive and knowing-in-practice becomes intuitive and spontaneous.

- Understanding as a co-construction, which is articulated as a phenomenological ability of a student nurse to enter into the real world of the patient and see things from the patient's viewpoint.

These two points made by Perry are pertinent to the present study. Both of these imply the *to-be-expected* or the proposed lived-world of student nurses in the clinical area. However, many issues, which ultimately reside in, and figure in, the choices individual students make, will determine that nature of their individual lived worlds; their experiences and perceptions of the clinical field as learning environment; the ultimate focus of this study.

#### **3.4.1.4 *Knowing the patient***

Although learning in the clinical field includes many different spheres including social learning, learning management principles and the like, the patient, and the student nurses' relationships with the patient, stays the main mutually responsive source of learning for student nurses. Knowing the patient is thus important.

Swanson (1991 cited in Radwin 1996:1142) defines knowing as striving to understand an event as it has meaning in the life of the individual. Tanner et al (1993:279) is of the opinion that knowing the patient is part of clinical learning and also believe that getting to know particulars about patients with similar illnesses allows the student nurse to learn about common issues and to make important qualitative distinctions within particular patient populations. According to Radwin (1996:1143), knowing the patient is a process of understanding and treating the person as a unique individual. According to the researcher's understanding of existentialism, if a student nurse treats the patient as a unique individual, that is where the "existential" of the patient could be learned. In this regard, Alexander (1990 as cited in Radwin 1996:1143) demonstrates the importance of knowing the patient, stating that it involves learning of the patient's thoughts, concerns, fears and hopes (existence). Johns (1996:40) asserts that if nurses really do care about patients as people, the response to clinical situations can only be made through knowing that person and how he/she sees the situation.

However, it is also true that in order to care for and about patients, student nurses must have an innate disposition towards this end and the environment must lend itself hereto.

Putting it differently the constituted lived-world of the student nurse at any point in time will influence her relationship towards whatever is redefining her lived-world and thus her perception and experience in the moment. The point sensitised by this section of the preliminary literature review is that during the present study, the researcher became receptive of student-patient relationships and the promoting and eroding potential these might have on students' constitution of a life-world; their perceptions and experiences of the clinical environment as a learning experience.

### **3.4.2 Factors related to the clinical facilitator**

In this section the term *clinical facilitator* refers, in addition to clinical facilitators proper, to all professional and registered members of staff in the clinical area who, by virtue of their professional obligation and responsibility are involved in student teaching and learning in the clinical area.

#### **3.4.2.1 Personal attributes of clinical facilitator**

Clinical facilitators' behaviour in the clinical learning environment plays an important part in the learning process of the student nurse. A phenomenological study conducted by Girot (1993) revealed facilitators' attributes such as trust, caring, communication skills, knowledge and adaptability to be important in promoting student nurses' learning. A phenomenological study undertaken by Nahas (1998:664) involving 48 Australian undergraduate students, indicated that one of the affective behaviours that student nurses rated important relating to the facilitator was a good sense of humour. Over and above, Mongwe (2001:129) found that a good facilitator is one who is a resource to student nurses as well as a role model.

Baillie (1993:1047) noted that several student nurses commented positively about their mentors' relationships with clients, considering observations of these relationships to be good for learning. In addition, Burton (2000:1013) sustains this view and maintains that student nurses could learn by developing a nurturing, safe environment through adopting a positive regard for, and an empathetic understanding with, facilitators. Qualities that keep the student nurses engaged include an enthusiastic facilitator, and one with good listening skills, rendering support, exercising mutual respect, patience,

self-confidence, friendliness, caring, and professional role modelling (Erickson-Owens & Kennedy 2001:139).

McCormack (1992 cited in McCormack & Hopkins 1995:162) also believes that a leader, including a facilitator by virtue of his/her position of authority, exerts influence, power and authority effectively, consistently and constantly within a specific sphere of influence. To illustrate this point, one is reminded that Lorentzen (1992 as cited in McCormack & Hopkins 1995:162) said that leadership implies authority in the widest sense, not just power to wield the stick.

#### **3.4.2.2 Professional knowledge and skills**

Nahas et al (1999:639), in a study involving Jordanian undergraduate student nurses, revealed professional competence as the most important attribute of the facilitator in promoting student nurses' learning. This is corroborated by several other authors.

In Baillie's (1993:1048) research student nurses articulated their gaining of more learning experiences with clinical facilitators' variable knowledge about course content. Clifford (1995:16) also agrees that the clinical skills of the teacher are important for the student nurses' development of nursing practice. Evans (2000:136) is of the opinion that the clinical facilitator should be a mature creative knower with the ability to incorporate what has been called procedural knowing, that is, objective analysis, or the 'voice of reason' (intuition), into her cognitive stance. In addition he/she should have the ability to employ connected procedural knowing, which emphasises learning through empathy and believing, rather than doubting (Evans 2000:136).

This is as it should be within the clinical learning environment based on the fact that if a student nurse becomes aware of knowledge gaps of the clinical facilitator in the clinical field, learning could be eroded.

Erickson-Owens and Kennedy (2001:139) insist that the facilitator must be well read and familiar with the current best evidence supporting practice. According to Erickson-Owens and Kennedy (2001:139):

- best evidence and clinical expertise are necessary to maintain clinical competence, which assist the student nurses' knowledge and skill development
- clinical teachers need teaching strategies that facilitate the students' immediate learning and encourage lifelong patterns of learning
- teaching skills and commitment to helping student nurses learn, are essential ingredients for rich learning experiences for the students

These factors relate to the presentation of a phenomenological field and lived world for students and are indubitably sensitising elements at the philosophical level in the present study.

Further, Collins (1987 as cited in Antrobus 1997:830) defines knowledge as both the facts and experiences known by a person or group of people. Ryle (1963 as cited in Rolfe 1997:93) distinguishes between generally knowing *how* to do something (for example, practical knowledge of how to respond to a patient following a bereavement) and knowing *that* something is the case (for example, academic knowledge that bereavement often follows a particular course). Rolfe (1997:94) assumes that it is possible that one might have academic knowledge, gleaned from the textbooks or lectures, but not the practical knowledge of how to apply it. The facilitator in the clinical learning environment is expected to articulate knowing *how* and knowing *that* or alternatively, *knowing how and can do*.

With regards to the present study knowledge as *knowing how* and *can do* is important in the constitution of a life world and the concomitant perception and experience of the life world as a lived world. Discrepancy in *knowing how* and *can do* on the part of facilitators might create an image of inauthenticity. With regards to students themselves, such a discrepancy may equally lead to a feeling of ambivalence figuring in the theory-practice conundrum leaving the student unsettled, withdrawn and not completely *in touch* thus hampering involvement and ultimately learning.

### **3.4.2.3 Presence of the facilitator/teacher**

Presence in the context of the present study means being there and interacting with student nurses within the clinical field. It is evident that the quality of student-teacher interaction in the clinical learning environment and the resulting presence of the

facilitator can either promote or erode the student nurses' learning in the clinical learning environment (Nahas et al 1999:639). According to Baillie (1993:1147), student nurses' relationships with facilitators encourage them to be more involved with what they are doing. This situation could in turn promote learning. Involvement in this instance implies the constitution of a life-world that would be more in accordance with the expected norms set for student nurses as prospective professionals. In this instance, learning might be improved.

Lee (1996:1129) in a study about the clinical role of the nurse teacher found that ideal teacher-student nurse relationships resulted from teachers' visits to the clinical area to see how students were progressing, to show interest, to teach students and to help with problems even though there was support from clinical staff. The presence of the facilitator, and consequently clinical learning too, could be enhanced further by effective communication between a student nurse and the registered nurse (Byrd et al 1997:351).

There remains the possibility that if facilitators in the clinical learning environment could avail themselves and model the desired leadership skills, student nurses could be motivated to learn. An additional summary of the preliminary literature review on the attributes of facilitators that promote learning within the clinical learning environments is exhibited in table 3.4.

<b>TABLE 3.4</b> <b>ATTRIBUTES OF THE CLINICAL LEARNING FACILITATOR</b> (Baillie 1993:1147; Byrd et al 1997:351; Nahas et al 1999:139)		
<b>PROFESSIONAL COMPETENCE</b>	<b>PRESENCE AND RELATIONSHIP WITH STUDENT NURSES</b>	<b>PERSONAL ATTRIBUTES</b>
<ul style="list-style-type: none"> <li>• Facilitates student nurses' awareness of their professional responsibilities</li> <li>• Genuine interest in patients' care</li> <li>• Is well informed and able to communicate knowledge to student nurses</li> <li>• Supervises and helps in new experiences without taking over</li> <li>• Provides useful feedback on student progress</li> <li>• Is objective and fair in the evaluation of the student nurses</li> <li>• Possesses the ability to stimulate the student nurses to want to learn in the category of professional competence</li> </ul>	<ul style="list-style-type: none"> <li>• Conveys confidence in and respect for student nurses</li> <li>• Realistic expectations of student nurses</li> <li>• Honest and direct with student nurses</li> <li>• Encourages student nurses to feel free to ask questions or to ask for help</li> <li>• Permits freedom of discussion and venting of feelings</li> <li>• Available to work with student nurses as situations arise in the clinical learning environment</li> </ul>	<ul style="list-style-type: none"> <li>• Displays a sense of humour</li> <li>• Admits limitations and mistakes honestly</li> <li>• Is self-controlled, cooperative and patient</li> <li>• Shows enthusiasm for teaching</li> <li>• Is flexible when the occasion calls for it.</li> </ul>

Overall, the sensitising importance of this section on the facilitator is that facilitators become *important others* to student nurses in the clinical field and that these individuals, and student nurses' relationships with these individuals, may greatly influence students' constitution of a life-world and their perceptions experiences as a lived-world.

### **3.5 EROSION FACTORS OF LEARNING IN THE DOMAIN OF CLINICAL FACILITATION**

Influencing factors in clinical learning could be either positive or negative depending on the situation. Merely changing the positive factors around would, however, not do. Some additional erosive (negative) factors are thus discussed in this section.

#### **3.5.1 Poor student-facilitator relationships**

Hart and Rotem (1994:30) found that although student nurses enjoyed the opportunity to work closely with staff and experience a sense of belonging; some staff members were identified as 'hostile and hanging around student nurses too much or leave them alone and lost'. As Hart and Rotem (1994:31) further point out, some student nurses felt that staff as facilitators were reluctant to accept them and work with them. Collins, Hilde and Shriver (1993 as cited in Byrd, Hood & Youtsey 1997:344) considered student nurses as being exposed to the bureaucratic conflicts and to the frustrations of the everyday world without a support person at their side. Mahat (1996:165) found that stressful events student nurses experienced in the clinical field include poor interpersonal relationships due to negative interaction with teachers.

Paterson and Groening (1996:1121) reported that clinical teachers who desire to be idealised by student nurses, experience a sense of betrayal when a student, who has previously idealised them, becomes emotionally attached to another clinical teacher. The present researcher also found evidence during an informal discussion with clinical facilitators, that some clinical facilitators were emotionally attached to student nurses at the expense of other clinical facilitators in the clinical learning environment. It was further commented that when these student nurses happened to be on duty with clinical facilitators who were not emotionally attached to them, student nurses might absent themselves from the clinical learning environments and adopt a sick role.

In a further study by Mongwe (2001:115) it was found that both students and clinical facilitators lacked interest in facilitating learning during clinical placement in the LP. It also became evident that student nurses' lack of interest in learning contributed to clinical facilitators' poor interest in facilitating learning.

### **3.5.2 Unfamiliar environments, stress and anxiety**

Unfamiliar clinical environments are associated with fear and nervousness that obstruct clinical learning (Davidhizar & McBride 1985:289). In a study conducted by Kleehammer, Hart and Keck (1990:186) regarding anxiety-producing situations, student nurses reported the fear of making mistakes in the clinical field as the main source of anxiety. Mahat (1996:165) also found that initial experiences regarding patient care as well as demeaning experiences negatively influenced student nurses' experiences of the clinical field as a learning field. Cleigh (1972 as cited in Mahat 1996:167) also cautions that overwhelming negative forms of stress generally serve to threaten and discourage learning rather than to provide a challenge. In this regard, Kleehammer et al (1990:187) advise that if learning in the clinical learning environment is to be facilitated, anxiety must be kept at a moderate level. Furthermore, nurse educators need to continue to examine which situations are anxiety-producing situations for student nurses, and what interventions can be instituted to decrease anxiety.

According to Neill et al (1998:19) novice student nurses also experienced confusion in the clinical learning environment. Admi (1997:323) offers useful advice in asserting that nurse educators should not avoid the responsibility of preparing student nurses to deal with their own stress and anxiety in the clinical reality; otherwise, they may not be able to cope adequately with patients' stress.

### **3.5.3 Gender and age-related issues as an erosive factor**

Byrd et al (1997:345) identified difficulties in the clinical learning environment, as arising from age and gender disparities along with differing expectations between the preceptor and the student nurse. These authors further mention that preceptors may feel overwhelmed and uncomfortable with their response as clinical teachers. Paterson (1995) (as cited in Paterson & Groening 1996:1122) addresses this issue by stating that some male student nurses experience difficulties in being taught by female clinical

teachers. In addition to this, Duke (1996:410) attributes nurses' reluctance to make decisions to their early socialisation style of training, which was under the direction of the medical profession; a prescriptive and authoritarian socialisation style.

Thus, the fact that student nurses are being thrown into an unfamiliar environment, gender related issues, as well as age and other differences between students and other actors in the clinical learning environment could contribute towards the erosion of learning in the clinical field.

### **3.5.4 Shortage of resources**

Mongwe (2001:108), as well Mafalo (2003:39-40), indicate that shortages of staff and equipment could have a serious impact on the health care system and professional integrity could be jeopardised thereby. These authors assert that shortage of staff and work overload could lead to stress and burnout in nurses resulting in diminished leadership and mentorship qualities. This could also have a serious impact on the quality of experiences and learning of student nurses in the clinical learning environment.

In this instance, the present study seeks to establish the student nurses' experiences of learning during clinical placements as *being-thrown* (an existential and phenomenological tenet) into these situations.

### **3.5.5 Facilitators and knowledge**

The knowledge level that facilitators maintain or propose, even pretend, to have, could negatively influence the relationship between the facilitator and the student nurse, and ultimately learning in the clinical area, in different ways.

*Insufficient* knowledge, as an erosive factor, spans a wide range of issues in addition to having factual knowledge. In this instance Hart and Rotem (1994:29-30) identified the following issues:

- Learning objectives not being clearly understood by either student or staff.
- Student nurses being unclear as to their role in the clinical learning environment

- Staff being confused about their dual teaching and patient care responsibilities when student nurses are placed in their area.
- Reluctance of staff members to critically evaluate and change current practices negatively influencing the quality of the learning experiences of students.

Lee (1996:1131) corroborates this by indicating that nurse teachers and staff often feel ill-equipped to deal with clinical teaching situations due to a lack of confidence and knowledge. Duke (1996:410) points out that clinical instructors' lack of educational qualifications contributes to their being unprepared for the complexities of their teaching role. This aspect found reference in the study conducted by Mongwe (2001:110) who also found that clinical facilitators had inadequate knowledge leaving them unable to guide and direct student nurses resulting in learning by trial and error. In this regard, De Simone (1999:21) points out that learning by trial and error in the clinical environment generates insecurity and erodes self-confidence. Insufficient knowledge and uncertainty disturb the mental balance of an individual in a specific situation (Chabeli & Muller 2004:62). This has a negative implication for both the facilitator and the student nurse.

On other hand, Paterson and Groening (1996:1122) assert that clinical teachers who feel that they are more knowledgeable and expert than student nurses may be envious of student nurses who excel in certain aspects of their clinical performance. Allphin (1987) (as cited in Paterson and Groening 1996:1126) indicates that clinical teachers experiencing envy of a student nurse may attempt to dispel the student nurse's success by becoming overly critical of the student. Gravett (1991 as cited in Klopper 1999:24) warns that the learning accompanist must never have an attitude of superiority.

### **3.5.6 Student nurses not meeting their defined role criteria**

To be human is to be an active agent who organises and reacts to influencing forces; as active subjects, people seek meaning in life and strive to attain valued goals and they are responsible and irreplaceable agents in charge of their lives (Becker 1992:15). Role clarity and role definition are implied by this statement. Both student nurses and facilitators actively "seek meaning in life and strive to attain valued goals" in the clinical learning environment. In this regard, Baillie (1994:155) points out that clinical staff do not understand the active role of some teachers in the clinical learning environment, hereby misinterpreting their participation and role.

In relation to the above, Paterson and Groening (1996:1126) point out that clinical teachers reach an impasse when they perceive that a student nurse does not care about patients or nursing, or is too lazy to expend the necessary effort to learn how to become a nurse – implying that student nurses do not meet the perceived role definition of what their part in the clinical learning area is. As Paterson and Groening (1996:1123) put it, *the attribution responses of clinical teachers to student nurses who are perceived as lazy or uncaring have been identified as withdrawal, labelling, confrontation and discussion with a student that she/he is not suited to nursing as a profession*. Duke (1996:411) reflects that clinical teachers experience feelings of anger, disappointment and frustration when they feel that the student nurse's performance is such that it could jeopardise patient care. This is in line with the findings of Mongwe (2001:114), where the participants reported that they experienced difficulties in facilitating clinical learning with lazy student nurses. This could impact on the student nurses' perceptions of the clinical field as learning experiences.

### **3.6 CONCLUSION**

The purpose of reviewing literature was to sensitise the researcher to issues involved in the clinical learning experiences of students and facilitators. Three major themes emerged from published works:

- The nature of the clinical learning environment
- Factors promoting learning
- Factors eroding learning

The following chapter (chapter 4) focuses on the research design including explanations of the research design, data collection techniques and methods to ensure trustworthiness and ethical considerations.

## Chapter 4

### Research design: qualitative paradigm

#### 4.1 INTRODUCTION

A research design is an overall plan for collecting and analysing data, including specifications for enhancing the internal and external validity of the study (Polit & Hungler 1995:32; Seaman 1987:169). The research design directs the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns & Grove 2001:223). According to Polit and Beck (2004:57), in a qualitative study, the research design is often referred to as an emergent design; emerging during the course of data collection.

The design used to implement phenomenology in order to explore the experiences of student nurses in the clinical learning environments falls within the qualitative research paradigm, placing this phenomenological study at the qualitative, descriptive, contextual design contributing towards the scientific pool of knowledge of nursing, at the interpretative and hermeneutic level. In this regard see section 4.2.

Within the qualitative research paradigm, studies and designs (often referred to in literature as qualitative methodologies) share a number of similarities in terms of overall goals and techniques, but there are actually a variety of theoretical and philosophical traditions that fall within the broad umbrella of qualitative research (Polit & Hungler 1993:32). In this regard, Rice and Ezzy (1999:15) state that the phenomenological concept of *intentionality* had an important influence on the development of qualitative research that examined the meanings and interpretations people give to their actions and experiences. In addition, Girot (1993:115) indicates that phenomenology, as *qualitative* research, is used to discover and understand the meaning of human life experiences. Further down the chronological line, phenomenology is viewed by Merleau-Ponti (1962 as cited in Beck 1997:409) as a qualitative research design, which is an inductive, descriptive research method that studies essences. As Rice and Ezzy (1999:14) indicate, the European phenomenology of Edmund Husserl (1859-1938), Alfred Schutz (1899-1959) and Martin Heidegger (1889-1976) forms the philosophical background to many of the more familiar theories and methods in qualitative research.

Contemporary qualitative research also include as a philosophical and meta-theoretical baseline, humanism and existentialism and humanistic-existentialism as implemented in the Duquesne tradition (Von Eckartsberg (1986), symbolic-interactionism in grounded theory (Blumer 1969) and post-modernism.

## **4.2 QUALITATIVE RESEARCH**

According to Creswell (1994:1), a qualitative study is defined as an enquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words (not statistics or numbers), reporting detailed views of participants, and conducted in a natural setting. This definition illustrates the *epistemology* involved in qualitative research, that knowledge is narrative (*linguistic*) in nature rather than *statistical* in nature. Polit and Hungler (1995:15) substantiate this by asserting that qualitative research involves the systematic collection and analysis of more participative narrative materials, using procedures in which there tend to be a minimum of researcher-imposed control. This implies that qualitative research in accordance with the demands of phenomenology is *naturalistic* in nature.

Consequently, qualitative research implies an inductive, holistic, emic (from the point of view of participants and informants), subjective and process-oriented approach to understand, interpret, describe and develop *theory* pertaining to a phenomenon (Burns & Grove 1995:35; Morse & Field 1996:199). Corroboratively, Benoliel (1984 as cited by Brink & Wood 1998:335) defines qualitative research “as modes of systematic inquiry concerned with understanding human beings and the *nature* of their transactions with themselves and with their surroundings” (I italicised). Qualitative research adopts a person-centred and holistic perspective that generates an in-depth account that will present a lively picture of the research respondent’s reality (Holloway & Wheeler 1996:8). All of these are in line with the dictates and stipulations of phenomenological inquiry into “lived experiences.”

### **4.2.1 Attributes of qualitative research**

Summatively, a qualitative research design, in accordance with phenomenological research endeavours, is characterised by:

- inductive reasoning
- an *emic* perspective
- idiographic data analysis (though nomothetic analysis eventually leads towards phenomenal descriptions)
- reality as being subjective and multi dimensional
- capturing and discovering meaning
- developing concepts in the form of themes, motifs and categories
- understanding of phenomena
- information richness
- modification of methods used to enrich understanding
- linguistic epistemology as data are presented in the form of words
- holistic analysis concentrating on the relationships between elements
- naturalistic , non-manipulative, unobtrusive, and non-controlling operations
- openness to whatever emerges
- absence of predetermined constraints or outcomes (Patton 1990:40; Burns & Grove 1997:335; Brink & Wood 1998:246)

Consequently, a qualitative design was employed in this research because

- the researcher desired to learn about the essences of student nurses' experiences
- data were collected in close proximity to a specific situation rather than by mail or telephonically (Miles & Huberman 1994:10)
- the research was conducted in an unstructured manner (Struwig & Stead 2001:56)
- such data provide *thick descriptions* that are vivid, nested in the real context, and have a ring of truth that has a strong impact on the reader (Miles & Huberman 1994:10)
- qualitative data emphasise people's *lived experiences*, and are fundamentally well suited for locating the meanings people place on events, processes, and structures of their lives (Miles & Huberman 1994:10)
- qualitative researchers attempt to present the data with "open minds" and acknowledge that all data are value laden (Struwig & Stead 2001:56)

#### 4.2.2 Disadvantages of using qualitative research

For the more quantitative oriented researcher the openness and emergent style of qualitative research might leave the impression that it is soft and easy to do. It is thus necessary that the disadvantages inherent in qualitative research be reported upon. These mostly result from the open and unstructured nature of qualitative research as opposed to the structure inherent to quantitative research, leaving the researcher at a loss as to how to proceed. This is especially the experience of novice researchers. The researcher in this instance also experienced the following:

- Qualitative research is *not* easy to conduct. As the researcher interviewed each participant guided by one research question, where other questions were asked based on the descriptions given by participants, unlike in quantitative research where closed-ended questions are used. Over and above the researcher had to describe in detail the data collection methods, also in view of the subjective nature of the data, the researcher tried to quote directly the words of the participants unlike in quantitative research where responses would be quantified into statistics.
- A long period of time (often years) is required to complete a study. The stages through which the researcher progressed from identifying the focus of the study, data collection, to the presentation of the findings required a time plan to expedite the process of completion. For instance, the study took about four years to complete.
- Data collection involved a large amount of unstructured narrative data that needed to be sorted and organised. A data supplement of 86 pages containing the verbatim results of the interviews was compiled. From this data, themes, categories and sub-categories were compiled. This resulted in 4 main themes, 16 categories, 65 sub-categories, 53 sub-subcategories and 778 statements. Chapter 6 attests to this. The task of analysing this data felt monumental, as some of the phrases and concepts did not fall easily into any one theme. However, the researcher soon recognised repeated words as she became a more experienced qualitative researcher.
- There are no fixed steps that should be followed and the study cannot be exactly replicated (Brink & Wood 1998:246; Burns & Grove 1997:80). This places an immense ethical obligation on the qualitative researcher to report truthfully what

has been observed. The researcher realised that a phenomenological study does not expect duplicate behaviour from duplicate data. Duplication may occur when meanings of experiences are similar and generalisations may be made based on these similar meanings.

What follows in this chapter is aimed at meeting the attributes of qualitative research and consequently to provide for the phenomenological description of the research topic or object of intention namely, student nurses' experiences of the clinical field as a learning field.

### **4.3 POPULATION AND SAMPLING TECHNIQUE**

According to Swanson-Kauffman and Schonwald (1988:100), the empirical phase of research begins with the identification of the population from which *participants* are selected. This relates to human participation specifically. However, elements within a population could include almost anything; persons, events, organisational units and case records (De Vos 2002:199).

#### **4.3.1 Population**

Terminology relating to population includes: universe, population, accessible and target population. *Universe* pertains to all persons (or elements) who possess the attributes in which the researcher is interested ( De Vos 2002:198). This term equates to Burns and Grove's (1993:236) definition of the term population, which also refers to all elements that meet certain criteria for inclusion in the study.

In addition, the term *target* population refers to a specific area within the broader population or universe in which the researcher is interested. The target population thus presents a specific subsection of the total population. This population might not be manageable due to its size, number, location, distribution and other practical considerations. In this instance the *accessible* population or *study* population (Brink 2006:123) becomes practical. This represents the section of the universe the researcher accessed and from which the researcher obtained data. In terms of the present study, the *universe* could be all student nurses around the globe allocated to clinical areas for clinical learning. The *population* is scaled down by Regulation R425 (as amended) to

student nurses in the clinical area in South Africa. Since this is a qualitative study and for practical reasons, it would not have been possible to interview all student nurses in the clinical field in South Africa, and due to the researcher's specific concerns, the population has been scaled down further to a *target* population namely the Limpopo Province of South Africa. The *accessible* or *study* population then became the student nurses allocated to clinical learning fields at Limpopo College of Nursing at the three campuses within the Limpopo Province registered for their second, third and fourth year, during academic year 2004/2005. Each of the four disciplines (general, psychiatric, community and midwifery) was addressed by the study.

<b>TERMINOLOGY</b>	<b>DISPERSION</b>	<b>DETERMINING FACTOR</b>
Universe	The whole world	Given
Population	South Africa	SANC Regulation R425 (as amended)
Target population	Limpopo Province of South Africa	Special interest and concern of the researcher
Accessible or study population	Sample from three campuses of the only nursing college in the Limpopo Province	Research design, paradigm and logistical issues.

#### **4.3.2 Sampling technique**

According to Miles and Huberman (1994:27), qualitative research usually involves small samples of people nested in their natural contexts and studied in depth unlike quantitative research, which necessitates large samples for reasons of representativeness and generalisability. Qualitative samples usually tend to be purposive rather than random. Table 4.2 summarises possible qualitative sampling techniques as proposed by Miles and Huberman (1994:28) and Patton (1990:182).

<b>TABLE 4.2</b> <b>SAMPLING TECHNIQUES MOST USEFUL FOR CONDUCTING QUALITATIVE RESEARCH</b> (Miles and Huberman 1994:28; Patton 1990:182)	
<b>TYPE</b>	<b>PURPOSE</b>
Purposeful sampling	Selects information-rich cases for in-depth study. Size and specific cases depend on study.
Extreme or deviant case sampling	Learning from highly unusual manifestations of the phenomenon of interest. Such as outstanding successes/ notable failures, top of the class/ dropouts, exotic events, crises.
Intensity sampling	Information-rich cases that manifest the phenomenon intensely, such as good students/poor students /above average /below average.
Maximum variation sampling	Documents unique or diverse variations that have emerged in adapting to different conditions. Identifies important common patterns that cut across variations.
Homogeneous sampling	Focuses, reduces variations, simplifies analysis. Facilitates group interviewing.
Typical case sampling	Illustrates or highlights what is typical, normal, average.
Stratified purposeful sampling	Illustrates characteristics of particular subgroups of interest; facilitates comparisons.
Critical case sampling	Permits <i>logical</i> generalisation and maximum application of information to other cases because if it is true of this one case it is likely to be true of all other cases.
Snowball or chain sampling	Identifies cases of interest from people who know people who know what cases are information-rich; good examples for study, good interview <i>participants</i>
Criterion sampling	Picking all cases that meet some criteria, such as all children abused in a treatment facility. Quality assurance.
Theory-based sampling	Finding manifestations of a theoretical construct of interest so as to elaborate and examine the construct.
Confirming and disconfirming cases	Elaborating and deepening the initial analysis, seeking exceptions, testing variations.
Opportunistic sampling	Following new leads during fieldwork, taking advantage of the unexpected, flexibility.
Random purposeful sampling	Adds credibility to sample when potential purposeful sample is larger than one can handle. Reduces judgement within a purposeful category (not for generalisations or representativeness).
Sampling politically important cases	Attracts attention to the study (or avoids attracting undesired attention) by purposefully eliminating from the sample politically sensitive cases.
Convenience sampling	Saves time money and effort. Poorest rationale; lowest credibility. Yields information-poor cases.
Combination or mixed purposeful sampling	Triangulation, flexibility, meets multiple interests and needs

From the abovementioned sampling techniques the researcher selected the following sampling techniques:

- convenience sampling
- purposive sampling
- theory-based (theoretical) sampling

#### **4.3.2.1 Sampling participants**

A purposive and convenient sample of five student nurses was randomly drawn from the Limpopo College of Nursing student corpse. Student nurses who participated in the present study had acquired clinical experience of various clinical facilities within the LP.

The student nurses included

- one second year student nurse
- two third year student nurses
- two fourth year student nurses

First year student nurses were excluded from the sample because data were collected when the first year student nurses were still novices in the clinical field. As reflected in table 3.3 novices lack practical knowledge and skill, hence the present study focuses on the lived experiences of the clinical field as a learning experience. Therefore, second, third and fourth levels student nurses appeared to be more suitable to provide information regarding their clinical experiences than first-year student nurses.

- ***Purposive sample***

Purposive sampling to guide the selection of participants in the study was also adopted. Burns and Grove (1997:306) point out that purposive sampling involves the conscious selection by the researcher of certain participants to include in the study. Sampling is thus based on the judgement of the researcher (Brink 2006:33). Understandably this type of sampling is also referred to as a *judgemental* sampling and is also representative of theoretical sampling (Brink 2006:133).

During the current study, a purposeful sample of five student nurses, from second, third, and fourth levels of student nurses following the R425 four-year comprehensive basic nursing diploma, currently or previously engaged in clinical learning environments, were selected to participate in the study. The following criteria enabled the participants to be purposefully selected to this study:

A student nurse had to be registered for the second, third or fourth levels of training in terms of Regulation R425, as amended.

Because of the multicultural composition of the LP's nursing students, the researcher purposefully included student nurses coming from different cultural backgrounds such as Venda, Tsonga, and Sotho. Nahas (1998:665) asserts that the lived experiences of student nurses coming from different cultural backgrounds would further enhance the richness of the data collected.

The characteristics of purposive sampling as outlined by Lincoln and Guba (1985 as cited in Struwig & Stead 2001:122) were adhered to as follows:

- The total sample was not drawn in advance as was the case in quantitative research, therefore, the sample size was not finalised before the study commenced.
- In a situation where the previous unit provided insufficient information or if contrasting information was needed an additional sampling unit was necessitated
- ***Convenience sample***

The term *convenience* sample is anonymous to *accidental* sample and *availability* sample (Brink 2006:132). Polit and Hungler (1995:232) refer to convenience sampling as the selection of the most readily available people as participants in a study. Burns and Grove (1997:303) articulate this by stating that in convenience sampling, participants are included in the study, because they happen to be in the right place at the right time. The right place in this instance represents the Limpopo Province College campus, as well as the hospital, as clinical learning field, selected for this research as discussed in section 4.3.2.2.

- ***Participants' profile***

Profiles of participants were not directly sought through a demographic survey as an aspect of data collection or analysis in the study. Instead, the focus of the enquiry remained on the descriptions of the experiences of student nurses with regard to the

clinical learning environment. However, participants shared information about themselves for inclusion in the study.

Table 4.3 summarises the 5 participants' profiles for inclusion in the study.

<b>PARTICIPANT NUMBER</b>	<b>GENDER</b>	<b>AGE</b>	<b>CULTURAL GROUP</b>	<b>YEAR OF STUDY</b>	<b>CLINICAL FIELD EXPERIENCE</b>	<b>NUMBER OF INTERVIEWS</b>
1	F	22	Sotho	4 <sup>th</sup> year	4	2
2	F	21 years	Sotho	2 <sup>nd</sup> year	2	2
3	F	25	Venda	3 <sup>rd</sup> year	3	2
4	F	24 years	Shangaan	3 <sup>rd</sup> year	3	2
5	F	27years	Venda	4 <sup>th</sup> year	4	2

#### **4.3.2.2 Site sampling**

Marshall and Rossman (1995:54) advise that site (and sample selection) should be planned around practical issues, such as the researcher's comfort, ability to fit into some role and access to a range of activities. As indicated in chapter one, the Limpopo College of Nursing comprised three campuses, namely: Giyani, Sovenga and Thohoyandou.

Permissions to conduct the research at these campuses were obtained as follows. An application letter to request permission to interview student nurses from the Limpopo College of Nursing was submitted to the Senior Manager Nursing Education at the Department of Health and Social Development in the LP. Permission was granted and the researcher was advised to produce the proof of permission from the Head of Department together with the ethical clearance from UNISA to the college campuses. Letters of permission are attached in appendix B of this thesis. After this, the researcher approached the head of the campus where the study was conducted to further grant permission and to identify student nurses who would participate. A convenient date was scheduled by the head of the campus to avoid interference with student nurses' examinations.

Arrangements were made with the head of the college campus regarding the follow-up interviews of participants who were interviewed during the first interview. The reason for this arrangement was to ascertain the whereabouts of these student nurses because they were distributed in different clinical fields. Two, third year student nurses were found to be doing practica in the hospitals. The fourth year students were attending a college block. The head of the campus then granted permission to conduct interviews and follow-up interviews and advised the researcher to make arrangements with the Chief Executive Officer (CEO) of the hospital. A visit to the hospital was then made, where the researcher produced a letter of permission to conduct this study to the CEO. The letter of permission is included as appendix B of this thesis. Since training of student nurses in the clinical field is the responsibility of the nursing services manager, the researcher was then referred to the nursing services manager to make arrangements in terms of the off duties of the students as well as the venue in which to conduct the interviews. The placement of the third year students thus determined the hospital sites at which the current research was conducted.

#### **4.3.2.3 *Theoretical sampling***

According to Brink (2006:132), theoretical sampling is a type of purposive sampling. This is corroborated by Coyne (1997:629) who states that theoretical sampling, or theory driven sampling, involves the purposeful selection of a sample in the initial stages of the study.

According to Coyne (1997:625), the researcher starts the study with a sample where the phenomenon occurs. The next stage of data collection commences when theoretical sampling begins. Miles and Huberman (1994:29) assert that sampling must be theoretically driven whether the theory is pre-specified or emerges as the researcher is progressing. Therefore, the researcher returned to the participants to get more information as indicated in table 4.4. Coyne (1997:625) presents a practical definition of theoretical sampling as the process of data collection whereby the researcher simultaneously collects, codes and analyses data in order to decide what data to collect next.

The general procedure is to elicit codes from raw data from the start of the data collection through constant comparative analysis as the data pour in. The same procedure was followed during the present research. However, the theoretically guided sampling was conducted based on the experience of each of the participants individually, so as to arrive at idiographic descriptions first before moving into nomothetic data analysis (or axial coding) (see chapter 5). This procedure is more in line with the phenomenological tradition and, up to the point where nomothetic analysis starts, less grounded theory oriented. This was an attempt on the part of the researcher to counteract method slurring between phenomenology and grounded theory as cautioned by Stern (1987:76-89). The turn towards nomothetic analysis, was further imperative in order to come up with a reconstruction and detailed generalisation of the phenomena involved in the experience of student nurses of the clinical field as a learning field. This attempt by the researcher is in a way suggested by Coyne (1997:629) who draws the following conclusion: "The ongoing sampling is termed theoretical because it is controlled or dictated by the emerging theory. Purposeful and theoretical sampling may be combined in one study as all variations of sampling may be seen as purposive sampling".

Theoretical sampling of literature to augment the data elicited through interviews was also carried out in the present study and formed part of the nomothetic analysis phase, whereas during the idiographic phase of analysis, the researcher returned to interview participants selectively on recurring themes that emerged from the data and on areas that needed more clarification. The number of items sampled in both cases depended on whether saturation of categories and completion of description had been obtained.

### **4.3.3 Sample size**

According to Drew (1989 431), with regards to qualitative research, the number of interviews is less important than the extent to which the phenomenon is explored in each interview. Although Becker (1992:41) indicates that the researcher must decide how many people to interview because more data make it easier to see the phenomenon's general structure. Streubert and Carpenter (1999:59) are of the opinion that predetermining the number of participants for any given study is impossible. Struwig and Stead (2001:124) corroborate this by declaring that it is not possible to

state what an ideal sample size is. These authors assert that qualitative researchers are more interested in whether the information from a sample is rich in data and thick in description than they are interested in the extent to which the data can be generalised to the population. This led the researcher during the present research to collect data until data saturation was achieved, fully aware of the “theoretical” nature of the concept of saturation.

#### **4.4 THE RESEARCH INSTRUMENT**

##### **4.4.1 The researcher as instrument**

Streubert Speziale and Carpenter (2003:18) state that “the researcher as instrument is another characteristic of qualitative research”. This is primarily founded on the researcher’s roles as observer, interviewer and interpreter. Streubert Speziale and Carpenter (2003:18) argue that the subjectivity inherent in this is not necessarily bad, but could contribute towards the richness of the findings of a qualitative study. These authors continue by pertinently pointing out that this qualitative trait is also reflected in phenomenological studies (Streubert Speziale & Carpenter 2003:18). In this regard, Henning, Van Rensburg and Smith (2004:81) indicate that apart from observation instruments and strategies, including open and structured interviews, “the researcher ‘becomes’ the instrument of observation and ‘sees for herself’ first hand how people act in a specific setting ...”. The contrast between quantitative and qualitative research in this regard is also pointed out by Glesne and Peshkin (1992:7) who equate the former to the “use of formal instruments” and the latter to “the researcher as instrument.” This is also reverberated by Lincoln and Guba (1985:37) who, in regard to “relationship of the knower to the known,” indicate that in naturalistic research (qualitative research) the “knower and the known are interactive, inseparable”.

The involvement of the researcher as *instrument* in qualitative research is perhaps best portrayed by the transformative role that the researcher plays during the research process. Reignharz (1987) (as cited in Streubert & Carpenter 1999:57) listed five steps in the phenomenological transformation process. These were also applied during the present study:

- People's experiences were transformed into language. During this step, the researcher, through verbal interaction (during interviews), created an opportunity for participants to share their experiences related to the factors that influence the facilitation of learning in the clinical learning environment.
- What was seen or heard were transformed into an understanding of the original experience. In this instance, the researcher in her study of lived experiences of student nurses, considered participants' original experiences and also kept field notes during interviews.
- What was understood was transformed into conceptual categories forming the essences of the original experience. Chapter 6 bears witness to this transformation.
- These essences were transformed into a written document that captured the researcher's understanding of participants' experience and their descriptions. During these transformations, insights were gained; therefore, the researcher had to involve participants in reviewing the final description of material to ensure that material was correctly stated and nothing was added or omitted.
- The initial written document was transformed into a final statement on the object of intention; an understanding that would clarify all proceeding steps. The resulting synthesis captured the meaning of the experience, giving an exhaustive description of the experiences of student nurses on the clinical situation as learning field (Reignharz 1987 as cited in Streubert & Carpenter 1999:57).

#### **4.4.2 The formula research instrument**

In addition to the innate "instrumentality" of the researcher in qualitative research, the researcher still needs some guidance as to how to go about eliciting the type of data necessary to answer the research question. With regards to the present research, in accordance with Swanson-Kauffman and Schonwald (1988:100), subsequent to specifying the desired population, the researcher in this phenomenological research generated a tentative interview schedule that served as a *prompting* device. Further in relation to the innate instrumentality of the researcher, Polit and Hungler (1995:273) advise that even though unstructured interviews are conversational in nature, this should not be entered into casually; in advance thoughts and purposeful preparations are required.

An interview schedule was therefore developed before in-depth phenomenological interviews were conducted. An interview schedule is defined by Taylor and Bogdan (1984:92) as a list of general areas on the topic of interest that need to be covered. In order to come up with an appropriate schedule to guide the researcher during data collection, the literature review was conducted.

The interview schedule is not a structured schedule or protocol. According to Moustakas (1994:116), a general interview schedule is used when the researcher's story has not been tapped into the experience. Nahas (1998:666) affirms that the interview schedule can be used to assist the researcher to focus on the phenomenon being studied.

In order to construct the interview schedule, most of the content of the interview schedule was adapted from Krueger (1988) and from Steward and Shamdansani (1998). Draft questions were formulated and carefully screened for clarity, ambiguity, sensitivity to participants' psychological state, culture and religion, and for freedom of any bias. As Miles and Huberman (1994:38) point out, an interview schedule can be modified steadily to explore new hints, to address revised research questions or to interview a new class of participants (as might be necessary during theoretical sampling).

For the present study, the interview schedule consisted of three (3) sections, namely:

- Section 1 included a checklist, objectives and introduction
- Section 2 contained the interview question
- Section 3 contained a conclusion

**Section 1** (see appendix C) of the interview schedule included the following issues:

- A checklist designed to assess the logistics and equipment in advance to rule out problems and interferences. The checklist included topics such as the size of the room, furniture, comfort, and the like.
- Objectives for the formal in-depth phenomenological interview based on the objectives of the research were formulated to guide the researcher during the session.

- The introduction, whereby the researcher followed the pattern recommended in Krueger (1988:80), greeting and welcoming each participant to the session. The researcher also introduced herself to the participants as well as thanking them for taking the time to accepting to share their lived experiences of the clinical field as learning experiences. Before the research question was asked, section1's questions were asked to obtain demographic data from the participants, in order to build demographic profiles. Detailed information is given in appendix C of this thesis.

**Section 2** comprised the following interview question:

- **How do you experience the clinical field as learning field?**

Alternatively:

- **How do you experience learning in the clinical fields?**

**Section 3** of the interview schedule comprised a conclusion. The researcher summarised briefly the main points with regard to student nurses' experiences. The researcher tried to convey an understanding of what the participants had said. The researcher also thanked the participants for participating in the study.

#### **4.4.3 The main focus of an interview question**

The researcher focused on one research question. The research question focused on the experiences that student nurses lived through. Other questions emerged as student nurses were answering the central research question and the conversation ensued. In this regard, Patton (1980) (as cited in Mullaney 1997:162) cautions researchers wishing to use phenomenology as a research method to be *truly phenomenological* in their execution of their research; not to develop a set of steps along which to proceed but to proceed as the direction of the *experience* indicates; without the restrictions structure would impose.

- **The research question per se**

The main focus of the research and interview question(s) were:

- **How do you experience the clinical field as learning field?**

Alternatively:

- **How do you experience learning in the clinical fields?**

The question(s) was (were) also negotiated with the participants in order to assure that they understood exactly what the researcher meant by the question. By having asked this question, the researcher assumed the following:

- ***Context***

This includes the student nurses' context - the world or situations, in which they lived in the clinical learning environments. The researcher aimed to understand student nurses as "being-in-the-world" with others. As Becker (1992:13) points out, people form networks of interpersonal relationships. For example, if student nurses define themselves as students, this aspect ties them to various interpersonal situations.

- ***Reflexion***

The researcher aimed at drawing upon student nurses' ability to think about their experiences, about themselves and about their interpersonal world; to objectify the self and the life world and living.

- ***Active participant***

The researcher assumed student nurses to be active, participating and experiencing individuals creating and co-creating their lived worlds and life-worlds within the clinical learning environment. As Becker (1992:14) indicates, to be human is to be an active agent who organises and reacts to influencing forces.

- ***Intentionality***

Not only did the researcher assume intentionality as directedness towards an object, but also intention as student nurses' strive to make *things* happen (student nurses intended to learn during their clinical placements). *Intentionality* is not the same as the word 'intention' of having 'good intentions.' As Watson (1999:119) indicates: The term *intentionality*, is a more technical, philosophical term meaning "being directed towards a mental object". Watson continues by citing Schiltz (1996:31) who defines *intentionality* as: "Philosophically, it is consciousness about something or some content of consciousness, such as belief, volition, expectation, attention, action, and even the unconscious".

- ***Unique experiences and essential themes***

As Becker (1992:23) states: "*we must listen to people rather than assuming that we know what they are telling us*". In the light hereof, the researcher wished to extract the common components from unique events from student nurses' descriptions of experiences, and illuminate the essential themes of unique experiences. Becker (1992:23) states that knowing the common features of human experience helps us to understand and work effectively with particular people. This assumes that notwithstanding individual uniqueness and differences, these are also human commonalities. These commonalities often reside in, and crystallise in, the language used to express lived experiences.

Probing questions, guided by the information elicited during interviews, were also used. These questions were thus not prepared in advance.

Example/of such probing questions include:

- What meaning does it have for you?
- How do you feel about this?
- What did you learn from this experience?
- What new things can you think of doing with it?

#### **4.4.4 Pretesting**

According to Polit and Hungler (1993:652), pretesting is an “administration of a newly developed instrument to identify plans or assess time requirements”.

During the present study, a draft interview schedule was given to two nurse researchers, who were knowledgeable about clinical facilitation in clinical learning environments, to check the appropriateness of its contents. The initial question was: How do you experience clinical experiences in clinical learning environments? This question was modified to: How do you experience the clinical field as learning experience?

The feedback from this review was incorporated into the interview guidelines. The initial samples of two student nurses were interviewed to obtain a broad overview of what the major issues and concerns were regarding clinical facilitation and learning in the clinical learning environment. This exercise also served to determine whether the participants understood the research question. Once the interview question was tested, the participants who were identified by the head of the college campus principal were interviewed.

#### **4.5 DATA COLLECTION**

Katz and Green (1997:160) define qualitative data as a documented observations and participants’ feedback, both verbal and written over a designated period of time. According to Polit and Hungler (1995:26), qualitative data are merely pieces of information obtained in the course of the investigation. In the context of this study, data are referred to as pieces of information obtained through transcribed verbal (narrative) descriptions of the experience of the clinical field as learning field.

*Without accurate data, there cannot be accurate analysis or solutions* (Katz & Green 1997:162). To obtain accurate data the researcher conducted in-depth phenomenological interviews using a single unstructured open-ended question and probing questions that resulted from the information collected during the interviews.

#### **4.5.1 In-depth phenomenological or qualitative interview**

Taylor and Bogdan (1984:77) describe the in-depth qualitative interview as repeated face-to-face encounters between the researcher and participants directed towards understanding participants' perspectives on their lives, experiences, or situations as expressed in their own words. Moustakas (1994:114) delineates the phenomenological interview as an informal, interactive process that utilises open-ended comments and questions. According to Streubert and Carpenter (1999:23), the formal unstructured qualitative interview, through open-ended questioning, is one of the most frequently used data collection strategies. In this regard, Becker (1992:38) points out that an open-ended question is asked at the beginning of the interview and then other questions are developed from the participants' replies. Patton (1990:296) maintains that truly open-ended questions allow the interviewee to select from among his/her full personal repertoire of possible responses. An open over-all research question does not presuppose which dimensions of feelings or thoughts are salient to the interviewer and this permits participants to take whatever direction, and use whatever words they want, in order to represent what they have to say (Patton 1990:297).

##### ***4.5.1.1 Motivation for selecting in-depth phenomenological interviews***

With the above definitions of the formal unstructured open qualitative research interview or the phenomenological interview in mind, the researcher chose this data collection method for the following reasons:

- The researcher could illuminate participative human experience (Taylor & Bogdan 1984:81).
- It allows both parties to explore the meaning of the questions and answers involved (Mullaney 1997:166).
- Areas of uncertainty or ambiguity can be clarified instantly to avoid misinterpretation (Mullaney 1997:166).
- It allows entrance into another person's world and is an excellent source of data (Streubert & Carpenter 1999:58).

- Intense concentration and rigorous participation in the interview process improves the accuracy, trustworthiness and authenticity of the data (Streubert & Carpenter 1999:58).
- Participants could be provided with the opportunity to fully explain their experiences of the phenomenon under investigation.
- Participants could be allowed to share their stories, in their own words, rather than being forced into pre-established lines of thinking developed by researchers.
- The researcher was allowed to follow a participant's lead, to ask clarifying questions and to facilitate the expression of the participant's lived experience (Streubert & Carpenter 1999:58).

Table 4.4 reflects the summary of the mode of a typical qualitative interview.

<b>TABLE 4.4 SUMMARY OF THE MODE OF TYPICAL INTERVIEWS (Kvale 1983 cites Becker 1992:42)</b>
<p>The mode of understanding in qualitative research interview</p> <ul style="list-style-type: none"> <li>• centres on the person's life worlds</li> <li>• seeks to understand the meaning of phenomena in his life-world</li> <li>• is qualitative, descriptive, specific and presuppositionless</li> <li>• focussed on certain themes</li> <li>• open for ambiguities and changes</li> <li>• depends upon the sensitivity of the interviewer</li> <li>• takes place in an interpersonal interaction</li> <li>• may be a positive experience</li> </ul>

In addition to the above, the following principles of unstructured interview guided the researcher to:

- suspend beliefs in the normal and taken-for-granted assumptions about the social world and its organisation, and instead attempted to discover how student nurses ordered their behaviour and interpreted their worlds
- focus on gathering detailed descriptive materials of the ways in which student nurses made sense of learning in clinical learning environments, without imposing personal concepts or categories of such descriptions (Beck 1993:167; 1997:409; Field 1996:131; Neill et al 1998:17)

#### **4.5.1.2 Limitations and coping measures during interviews**

Field (1996:132-134) indicates that the success of interviewing lies simply in avoiding the limitations inherent in this data collection method and in coping with these as they arise during the course of the interview. The measures applied in this regard are as follows:

- *Establishing and maintaining rapport.* Student nurses were encouraged to talk openly about their experiences, criticised other staff at all levels and displayed their emotions openly.
- *Unobtrusively controlling the interview.* The researcher remained unobtrusive and depended on good interpersonal skills. Participants were generally relaxed and friendly.
- *Interviewer and interviewee status.* Student nurses were encouraged and allowed to talk without guiding their responses.
- *Over involvement as personally damaging.* The researcher avoided identifying closely with the topic being researched and/or with the participants to maintain balance.

#### **4.5.1.3 Arrangements for the interviews**

The boardroom of the college campus of the Limpopo College of Nursing was used as a venue to conduct the interviews. The participants who were selected to participate in the research were contacted telephonically and appointments were scheduled at a time convenient to each participant. The head of the campus again assisted in this matter. Interviews conducted at the hospital were arranged with the nursing services manager through the chief nursing executive officer.

In accordance with Becker (1992:39), the interview venue was private, free from interruptions and one in which interviewees felt comfortable. These arrangements are also corroborated by Rose et al (1997:1127) who advise that the researcher should make the interviewee as comfortable and relaxed as possible; if interviewees are to disclose personal experiences they need to feel safe and secure. It was argued that the more comfortable each participant felt, the more likely it was that he/she would reveal the information sought (Streubert & Carpenter 1999:23). It remains the researcher's

responsibility to create a relaxed climate (Moustakas 1994:115) in which the participant feels comfortable and prepared to respond to the interviewer honestly.

#### **4.5.1.4 Conducting interviews**

The researcher adhered to the following interrelated activities as pointed out by Becker (1992:38), Field (1996:136), as well as Streubert and Carpenter (1999:57) while conducting the interviews.

- ***Beginning the interview***

The researcher commenced an interview by reiterating issues of confidentiality, anonymity and progressed to the purpose of the interview. Informed consent was obtained from student nurses prior to conducting the interview. Detailed information regarding ethical considerations is given in section 4.7 and an example of informed consent is given in appendix C. Permission was required from each participant to tape-record the conversation in order to ensure accurate transcription allowing the researcher to linger with the data. The researcher explained the rationale for tape-recording to each participant and also indicated that tapes will not be made available to anyone except the researcher. Each student nurse was assured of confidentiality, emphasising that no names would be used anywhere; participating student nurses were to be identified by letters of the alphabet (A-Z). All participants agreed to have their interviews recorded as described in section 4.7 on informed consent (an example of informed consent is given in appendix C).

Each interview started with a statement of the purpose of the study (see section 4.4.2 on the structure of the interview schedule) and how the interview would be conducted. The researcher engaged in the “Epoche” process or so-called “bracketing” described earlier in chapter 2 and also in section 4.8.1.5 as part of “reductive phenomenology.” This was done so that, to a significant degree, past associations, understandings, “facts,” biases, and the like the researcher had about the object on intention, were set aside so as not to influence or direct the interview. Moustakas (1994:116) specifies that engaging in the “Epoche” process should also be indicated during interviewing.

The researcher commenced with a social conversation as a brief mediating activity

meant to establish rapport and a relaxed and non-threatening atmosphere. During this phase, the goals and objectives of the research were conveyed to the participants, issues surrounding informed consent were discussed and the informed consent forms were signed (see section on ethics relating to the present research section 4.7). The initial mediating conversation was guided to proceed into nursing, being a student nurse and eventually into the research question on the experience of the clinical field as learning field.

Participants were asked to fully explore their experiences; to elaborate on the events, feelings, memories, meanings and thoughts involved in their experience. In accordance with Becker's (1992:38) recommendation, the researcher even-handedly probes the descriptions for elaborations and depth of details while simultaneously noticing salient features and probing these through follow-up questions used to fathom the interviewer's response (Patton 1990:324). In the same vein Becker (1992:38) and Kosowski (1995:237) advise researchers to continue requesting explanations until participants respond that they either could not remember or wished not to recall any further details. While requesting explanations and details, the researcher noted the essential features of learning in the clinical field.

During the interviews, the researcher consciously avoided leading and evocative questions. However, to further fathom the experiences of participants, the researcher, in accordance with Becker (1992:41), asked herself the following salient questions during the interviews:

- Can I summarise the essential features of this phenomenon?
- Did I gather enough examples and details?
- Does the person have anything else to say about this aspect of the phenomenon?
- Do experiences surrounding the phenomenon exist that the interviewee has not yet mentioned?

Deliberating these questions the researcher remained centred on the data, listened attentively, avoided interrogating participants unnecessarily and treated them with respect and sincere interest. This was maintained through both the initial and the follow-up interviews with participants. The latter resulted from, as Field (1996:134) suggests,

reviews of the initial interview transcripts which open, new areas or topics for further interviewing; theoretical interviewing so to speak.

#### **4.5.1.5 Follow-up interviews**

Follow-up interviews with participants were conducted with three participants at the nursing college campus and two participants in the clinical field. Additional permission for the latter was obtained from the chief executive officer of the hospital to which these students were allocated for clinical experience. This technique results in a clarification and/or expansion of the information (Paterson 1997:199). Data generation or collection has continued in this manner, integrating data analysis and data collection, until saturation was achieved; when no new themes or essences emerged from the data and data became wholly repetitive.

## **4.6 DATA ANALYSIS**

The process followed to analyse the data during the present research is discussed in detail in chapter 5. At this point only a general overview of data analysis in qualitative research, in line with the research design, is given.

Streubert and Carpenter (1999:28) point out that qualitative data analysis begins simultaneously with data collection whereby researchers keep, and constantly review, records to discover additional questions or descriptions of their findings while conducting interviews or observations. According to MacMillan and Schumacher (2001:462) discovery analysis strategies are used to develop tentative and preliminary ideas during data collection. In addition, Miles and Huberman (1994:10) indicate that during the analysis of qualitative data, researchers reduce data throughout the process. These authors refer to data reduction as the process of *selecting, focusing, simplifying, abstracting* and *transforming* the data that appear in compiled field notes or transcriptions. The final result hereof is clusters of ideas referred to as *themes*, which give structure to data (Streubert & Carpenter (1999:28), assisting in the discovery of meanings inherent in what was observed and heard. Meaning is further arrived at by reading, rereading, and reflecting upon significant statements in the original transcripts. Streubert and Carpenter (1999:28) assert that once researchers have explicated all

themes relevant to a study, they write it up in a way that is meaningful to the intended audience.

The above issues are usually achieved through the general sequence of events in qualitative data analysis as summarised by Tesch (1990:95-97), namely:

- conducting a systematic and comprehensive, though not rigid, analysis which proceeds in an orderly and disciplined fashion in an organised mind, characterised by perseverance
- attending to data via a reflective activity resulting in a set of analytical notes that guide the process
- segmenting data, in other words, dividing data into relevant and meaningful units, a process commencing during the first reading of the raw data to achieve 'a sense of the whole', fertilising the interpretation of individual data pieces
- 'interrogating' parts of the data with regard to items they contain, forming themes and categories
- comparing and contrasting data units during analysis, forming categories, establishing boundaries for categories, assigning data segments to categories, summarising the content of each category and finding negative evidence; all done to discern conceptual similarities, to refine the discriminative power of categories, and discovering patterns within the data
- ensuring that categories are tentative and preliminary in the beginning, and that they remain flexible

Tesch's explication, and those of the other authors referred to, do not emphasise picture the mental operations involved in qualitative data analysis though understanding. These are of the utmost importance in qualitative research, in general, and in phenomenological research in particular. For this reason the researcher turned to the work of phenomenologists from the Duquesne tradition, more specifically the work of Wertz (1983, 1985), to prepare herself for data analysis.

#### **4.7 ETHICAL CONSIDERATIONS**

Ethics in research are defined as a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal, and social

obligations during the research (Polit & Hungler 1995:641). Qualitative research brings with it a new set of ethical considerations. Working with the human subject emphasises informed consent, anonymity and confidentiality, trustworthiness of data generation and treatment, and participant-researcher relationships in a special way (Streubert & Carpenter 1999:33).

This section outlines the ethics adhered to during and after the study, as these relate to:

- the participants
- the institution
- the scientific integrity of the researcher

#### **4.7.1 The participants**

Participants are the qualitative researchers' first concern. Although physical trauma to participants may not be a likely occurrence during qualitative research, psychological and emotional trauma might occur. The following issues thus become important regarding the participant.

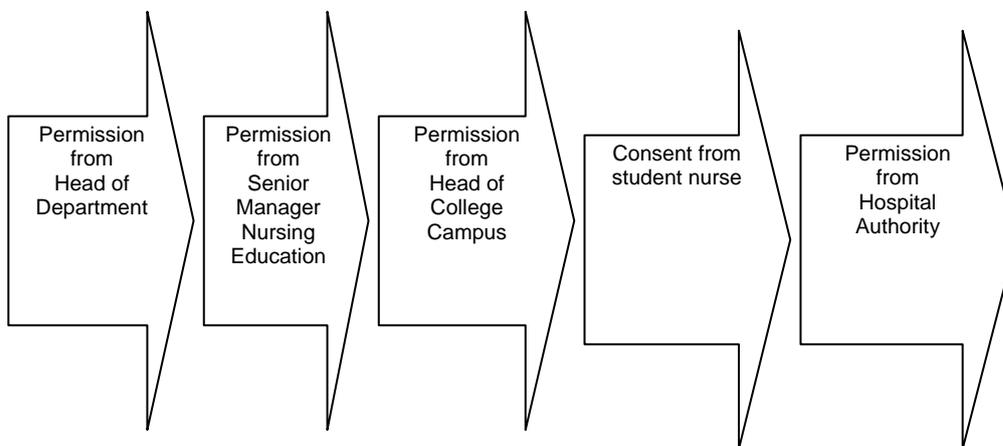
##### **4.7.1.1 Informed consent**

According to Polit and Hungler (1995), informed consent means that participants have adequate information regarding the research; are capable of comprehending the information; and have the power of free choice enabling them to consent voluntarily to participate in the research or decline participation. This refers to establishing and maintaining *autonomy* on the part of the participant. Hammersley and Atkinson (1995:264) corroborate this by stating that participants should give their unconstrained consent. Louw and Edwards (1998:54) acknowledge the importance of informed consent by stating that researchers should obtain informed consent from participants before the research begins. Streubert and Carpenter (1999:37) warn that a researcher's integrity can become damaged if the researcher uses deception to generate data.

A written explanation of the research along with a written consent form was provided to participants. The researcher offered an explanation of the research, and the nature of, and the reasons for and the purpose of, the study. The methods and procedures to be

used were explained clearly to participants. Informed consent also included seeking permission from participants to audiotape interviews. The role of the researcher was also clarified namely that she conducted the research as an independent researcher and not as a representative of higher authority. This was especially necessary to allay participants' fears in the clinical area.

Consent was authenticated by having participants sign an official consent form (appendix C). Figure 4.1: displays the process, which the researcher went through to arrive at obtaining consent form participants. This laid the foundation for ascertaining prevention from harm. Confidentiality and anonymity were maintained as pointed out in sections 4.7.1.3 and 4.7.1.4 respectively.



**FIGURE 4.1**  
**PROCESS OF HOW CONSENT WAS OBTAINED**

#### **4.7.1.2 Preventing harm**

All participants in this study were assured of freedom from any harm, whether psychological or physical. Hereby the ethical principles of beneficence (doing what is good) and non maleficence (preventing causing any harm) were upheld (Streubert Speziale & Carpenter 2003:314).

Personal dignity and autonomy of participants were maintained within the broader definition of doing good and causing no harm by having carefully considered *why* questions during the in-depth phenomenological interview where participants might have felt threatened. Steward and Shamdansani (1990:65) point out that the way in

which questions are worded may place participants in embarrassing or defensive situations. In addition, the researcher did not attempt to correct participants' beliefs and attitudes, during the research. Not only would this have skewed the data; it could also have caused emotional unease to participants. Also, this was necessary to maintain the "naturalistic nature" of the research. The researcher acknowledges the fact that some data reflected unacceptable conduct and behaviour by informants and whether to ignore these or to comment on these created an ethical dilemma for the researcher. The researcher trusts that the implementation of the results of this research will remedy this.

#### **4.7.1.3 Confidentiality**

According to Burns and Grove (1997:204), confidentiality is grounded on the basis that individuals can share personal information to the extent they wish, and are entitled to have secrets. Thus confidentiality necessitates *privacy*. The latter was secured by the choice of interview venue and the timing and spacing of interviews with different participants.

One can choose with whom to share personal information. Those accepting information in confidence, have an obligation to maintain confidentiality. In qualitative research it is, however, difficult especially when close relationships and friendships develop between the researcher and participants, to distinguish between what is said in confidence to the researcher as researcher or as friend. The latter should not find its way into the data.

During the present research the researcher fortunately did not experience this problem, probably because of the professional power differential that existed between the researcher and the participants, which in and of itself has certain ethical implications, such as the possibility towards exploitation of the participant as a vulnerable individual. However, the researcher's attempts towards preventing harm and promoting personal dignity of participants resolved this situation. Confidentiality was maintained by ensuring that any information provided by the participant was not made accessible to parties other than those involved in the research. However, permission to use direct quotes was acquired and the researcher ensured that examples of raw data would not reveal any participant's identity.

#### **4.7.1.4 Anonymity**

Anonymity is closely related to confidentiality and occurs when even the researcher cannot link a participant with the data (Polit & Hungler 1993 363). According to Polit, Beck and Hungler (2001:138), confidentiality is a guarantee that any information the participant provides will not be publicly reported or made accessible to parties other than those involved in the research. While anonymity aims to ensure that participants' identities are not revealed in presentations, reports, and publications of the study (Burns & Grove 2001:207). The researcher must respect the confidentiality (privacy) of participants (Struwig & Stead 2001:69) and others involved in the research project. Louw and Edwards (1998:54) cautions that if the participants are worried about confidentiality and anonymity, they may not give accurate information. These authors suggest that in qualitative studies where detailed personal information is obtained and included in the researcher's report, participants need to know how the material will be reported. In this report, the results from the *nomothetic* phase of data analysis and reconstruction are emphasised and reported rather than pure idiographic descriptions. This, to a great extent, contributes towards the anonymity of participants; reducing the possibility of linking an individual to a specific phrase. Permission to make the results public was, however, requested. In addition, the names of participants were not recorded during in-depth phenomenological interviews. Codes were used to link any follow-up interview to the corresponding initial interview. The principles of beneficence and justice are inherent in the principles of confidentiality and anonymity (Streubert & Carpenter 1999:38).

Informing the participants that the information recorded during phenomenological interviews and follow up interviews would not be linked to participants, ensured anonymity.

#### **4.7.2 The institution**

According to Van der Wal (2005:154), "it is imperative that the institution be treated as a *person* by the researcher".

#### **4.7.2.1 Informed consent and permission**

Permission to conduct the study in the LP was granted by the Department of Health and Social Development. Letters of permission from the Limpopo Provincial Department of Health and Social Development are included in appendix B of this thesis. The researcher submitted application letters, the research proposal and copies of letters confirming that permission had been granted by the Department of Health and Social Development to conduct the study to the Senior Manager Nursing Education Directorate in the LP to obtain permission to make arrangements with the head of the college campus where the study was to be conducted. Permission to conduct the study, with their full consent, was also obtained from the hospital management where student nurses were allocated for clinical experiences.

#### **4.7.2.2 Anonymity**

To comply with the principle of anonymity at the institutional level, the researcher omitted the names of specific hospitals on documents. Institutions and participants were not named, the hospitals, and the nursing colleges where the study was conducted were given pseudonyms.

#### **4.7.3 Scientific integrity**

The scientific integrity of the research refers to the researcher's competence in research and the way in which the researcher adheres to the ethical implications each and every step of the research process. What was said previously regarding the participants and the institution thus also bears witness of the researcher's scientific integrity. As such, the scientific integrity of the researcher gives evidence of the researcher's principled application and implementation of the research process as well as the researcher's expertise.

##### **4.7.3.1 Competence**

The competence of the researcher to conduct the present research was acknowledged by the Research and Ethics Committee of the Department of Health Studies, University of South Africa, by approving the research proposal and approving that the research

may be conducted. In addition, a promoter and joint promoter were appointed to augment the researcher's competence. Notwithstanding this, the researcher was mindful about conducting research in the clinical field, keeping in mind that research conducted for the purpose of advancing an academic qualification, though evaluated with certain educational aims in mind, should meet the ethical standards required for all such research (Van der Wal 2005:159).

Overall, with regards to the scientific credibility of the researcher, *deception*, something that must be avoided at all cost, becomes an important issue. Deception refers to misleading participants in such way that had they been aware of the nature of the study, they may have declined to participate in it (Struwig & Stead 2001:69). It is, however, not only participants that can be deceived. Funding institutions, the institution at which the research is conducted, the general public, all can in some way be deceived by the researcher. To avoid deception accurate information was given to all parties involved in the research. Exposed deception can lead to those being deceived feeling embarrassed, emotionally uncomfortable, or humiliated (Struwig & Stead 2001:69), especially the researcher himself or herself.

On reflection the researcher is satisfied that she complied with the five general principles as pointed out by the American Psychological Association (1992 as cited in Struwig & Stead 2001:67) in that she:

- Was qualified and competent to undertake a particular research project.
- Proved her scientific integrity through honesty, fairness, and respect toward all involved and by not having attempted to mislead or deceive anyone.
- Upheld the standards of her profession and accepted responsibility for her actions.
- Respected the rights and dignity of others, including respecting the privacy, confidentiality and autonomy of all involved.
- The social development of others was a major concern to her.

In addition, the researcher was compelled to be truthful in planning and conducting the research and writing the report, not to withhold, change or fabricate information. Furthermore, final data interpretations of the researcher were given to a panel of experts in qualitative research to verify, thus having consensus on the final report. All of

these would, however, be insignificant had the research not complied with the principles and criteria for establishing *trustworthiness*.

#### 4.8 TRUSTWORTHINESS

Krefting (1991:215) indicates that researchers need alternative models appropriate to qualitative designs that ensure rigour without sacrificing the relevance of the qualitative research. According to Beck (1994:254), reliability and validity are two criteria of logical empiricism that appear to be imposed upon phenomenology as a research method. However, among phenomenologists themselves, there is a lack of consensus regarding the issues of reliability and validity in phenomenological studies. Table 4.5 exhibits two sets of “qualitative definitions” of the terms reliability and validity.

TABLE 4.5 RELIABILITY AND VALIDITY IN QUALITATIVE AND PHENOMENOLOGICAL TERMS	
RELIABILITY	VALIDITY
The degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions (Hammersley 1990:57 in Silverman 2000:175).	“Truth” interpreted as the extent to which an account accurately represents the social phenomena to which it refers (Hammersley 1990:57 in Silverman 2000:175).
<i>Reliability</i> is observed when one can use this essential description consistently (Giorgi cited in Beck 1994:259).	<i>Validity</i> , in a phenomenological sense, has been achieved if the essential description of a phenomenon truly captures the intuited essence (Giorgi cited in Beck 1994:258).

As indicated the terms reliability and validity are quantitative research concepts. These are replaced in qualitative research by *trustworthiness* (Agar 1986 as cited by Krefting 1991:215). Sandelowski (1993:2) contends that trustworthiness becomes a matter of persuasion whereby scientists are viewed as having made those contextually grounded linguistic and interpretive practices visible and, therefore, auditable; that is less a matter of claiming to be right about a phenomenon than of having practiced good science.

Lincoln and Guba (1985:301) point out that in qualitative studies, trustworthiness may be operationalised under four *strategies* namely: credibility, transferability, dependability and confirmability. Beck (1994:262) is of the opinion that Lincoln and Guba’s four major *criteria* for rigour in qualitative inquiry namely: truth-value, applicability, consistency, and neutrality may offer phenomenologists an appropriate alternative to logical positivist terminology.

### **4.8.1 Credibility**

Credibility is a criterion referring to confidence in the truth of the findings of a particular inquiry for the participants (Lincoln & Guba 1985:291). Credibility includes activities that increase the probability that credible findings will be produced (Streubert & Carpenter 1999:29).

Credibility could be accomplished through prolonged engagement, triangulation, member checking, peer examination, authority of research, and structural coherence (Krefting 1991:215-217).

#### **4.8.1.1 Prolonged engagement**

In the context of the present study, prolonged engagement was achieved not only through the time spent with students during interviews whether in a formal setting or in the clinical setting. In addition, the researcher is a nurse educator, with nine years experience of teaching student nurses following basic nursing programmes and seven years of facilitation of both theory and practical work for undergraduate students following an open learning programme with the University of the North West. In addition the researcher spent almost eight years of continuous involvement with the research topic theoretically through intensive literature reviews and casual reading about the phenomenon.

#### **4.8.1.2 Triangulation**

Triangulation refers to the use of multiple methods or perspectives to collect and interpret data about some phenomenon in order to converge on an accurate representation of reality (Polit & Hungler 1993:448). Triangulation is further explained by Knalf and Breitmayer (1989) (in Krefting 1991:219) as a powerful strategy for enhancing the quality of the research. This author further indicates that this strategy of providing a number of different slices of data also minimises distortion. In this study, method and data triangulation was used.

**Method triangulation** involves combining two fundamentally different data gathering methods (Thomson & Jolley 1997:187). During the present study these methods included in-depth phenomenological interviews and follow-up interviews. The purpose of these methods was to gain insight from different points of view with regard to experiences of student nurses of clinical learning environments as a learning experience. Combining the two methods of data collection provided a clearer picture of how clinical facilitation is experienced by student nurses. According to Kimchi et al (1991 cited in Thomson & Jolley1997:190), the goal of triangulation is to circumvent the personal bias and deficiencies intrinsic to a single method of data collection. Therefore, interviewing student nurses regarding their experiences of clinical facilitation and conducting follow-up interviews of such experiences did not reflect the researcher's notion. In addition, a literature study was done to help the researcher to set a framework for in-depth phenomenological interviews.

**Data triangulation.** This was achieved through reviewing relevant literature, and by collecting data via interviews from second, third and fourth year levels of student nurses. Krefling (1991:219) is of the opinion that a different grouping of people contributes to a more complete understanding of the concept under study.

To avoid misconstruction, the exact meaning of the research question was explained to each participant (in a sense the research question was negotiated) and further expanded upon by means of asking probing questions during each interview.

#### **4.8.1.3 Member checking**

According to Sandelowski (1993:7), member checking is a way of enhancing the rigour of qualitative work through specifying a set of auditable practices and by virtue of its congruence with the qualitative goal of presenting experiences from the participant's point of view. Auditability is explained in section 4.8.4.1. From the forum of earlier phenomenology, Colaizzi stresses validation of the exhaustive descriptions of the phenomenon under study by the participants themselves; of the participant as co-researcher. This is unlike Van Kaam who expects judges to validate the steps of his/her analysis such as peer reviews. In contrast, Giorgi argues against the use of participants in a research study for validating of the findings (Beck 1994:259). According to Giorgi, to ask participants to evaluate a psychological interpretation of their own descriptions,

either implicitly, or explicitly, exceeds the role of participants. For Giorgi, casting the participant into the role of the evaluators overlooks the fact that participants describe experiences from an everyday perspective. Sandelowski (1993:7) cautions that members may be uninterested in participating in such an exercise, while Kosowski (1995:237) suggests that the researcher should consult the participants to obtain confirmation that the report has captured data as constructed by participants, or to correct, amend or extend it: that is, to establish credibility of the case.

To ensure the credibility of the data for the current study, student nurses who participated reviewed all descriptions and categorisations of their experiences with regard to learning in the clinical environment to validate that it accurately captured the essence of their lived experiences. To ensure trustworthiness of data analysis, the researcher returned to each participant and asked whether the descriptions reflected their experiences. This was mainly achieved through follow-up interviews. Participants' contributions were incorporated into a revised description. Incorporating these descriptions was helpful in establishing authenticity and trustworthiness of the data. Additionally, numerous quotes from student nurses were included in the results of the study to provide thick slices of data.

#### **4.8.1.4 Peer examination**

Earlier phenomenologists such as Van Kaam (1966 in Beck 1994:260) insisted that critical comparisons by more than one phenomenologist should be done to ensure *validity* of data. Similarly, independent checking by colleagues as well as supervision by experts was done during data analysis. The researcher re-coded the presented data by means of sending raw data to an independent coder who is an advanced researcher, experienced in conducting qualitative research. The independent coder was not provided with any pre-arranged themes or categories. Only a protocol with guidelines for data analysis was given. Intra participative agreement between the researcher and an independent expert was reached regarding themes and theme clusters.

#### **4.8.1.5 Authority of researcher**

Since the researcher is the main instrument in qualitative inquiry, a qualitative report must include information about the authority of the researcher (Patton 1990:427). This

authority relates to the researcher's competence discussed in section 4.7.3.1 and the researcher as the main instrument in qualitative research discussed in section 4.4.1.

With regards to the present research, the researcher was exposed to and trained in conducting qualitative research during her MA Cur studies. As indicated earlier, the researcher is a nurse educator, with nine years experience of teaching student nurses following a basic nursing programme and seven years of facilitation of both theory and practical work for undergraduate students following an open learning programme with the University of the North West.

The authority of the researcher, in terms of qualitative research could be both beneficial and detrimental to research. With regards to the latter, the problem of *authority* skewing data and interpretation is imminent if not guarded against. Bracketing becomes important in this instance in both securing trustworthiness of the research and in reflecting the scientific integrity of the researcher.

- **Bracketing**

Bracketing is discussed in section 2.6.4 as part of reduction phenomenology. During data collection, the researcher applied bracketing, a reinterpretation of the Husserlian phenomenological concept "epoch." Bracketing involves the deliberate examination by the researcher of his/her beliefs, knowledge, feelings and partiality about the object of intention or research topic. Swanson-Kauffman and Schonwald (1988:99) point out that the setting aside of the researcher's assumptions both prior to and during the actual data gathering, is a methodological attempt to accurately portray the reality of participants; *an ethical dictum*. These authors also assert that bracketing is a tool to bridge the gap between the researcher's own experience of the phenomenon as it is lived or experienced and descriptions of those lived experiences by the participants. Mullaney (1997:163) adds that bracketing appears to enhance the trustworthiness of the method and contributes to its rigour. Gordon (1997:146) emphasises that fundamental to the phenomenological method of investigation is the rigour accompanying its most basic exercise, bracketing. Drew (1989:431) is of the opinion that although the phenomenologist strives to suspend preconceptions and let each participant's truth present itself, as an interviewer and researcher, he or she is very much involved in the process with each participant. Accordingly, during the course of study, the interviewer's

involvement with the participants can be explored, particularly how the interviewer's emotional response to the participants as persons influences the study (Drew 1989:432).

In relation to this, Swanson-Kauffman and Schonwald (1988:99) state that bracketing is a concerted attempt to negotiate the empirical with the experiential based on the assumptions that:

- Researchers are capable of eliciting and hearing the reality of their participants.
- Participants express a reality sufficiently unique or cohesive so that any priori assumptions on the part of the researcher will not influence their interpretation.

During the present research bracketing was accomplished by bringing to mind, and keeping in mind, what the researcher already knew about the research topic. The initial limited literature review (chapter 3) assisted in this. In addition, the interrogation of data, during and after interviewing, involved ascertaining that existing mental structures of the researcher did not skew the information participants came up with. In a sense, the researcher became a layperson and the participants the experts.

In addition, guided by the above-mentioned assumptions, assertions and significance of bracketing, the researcher kept in abeyance her perceptions and knowledge about clinical facilitation, clinical teaching and clinical learning to the extent possible during the present research. This was achieved by the researcher who:

- Freed herself from bias by reflecting on personal experiences in the clinical field and set aside personal assumptions arising from these experiences. In addition, the researcher rigorously attempted throughout the research process not to impose any values on the emerging data. She further acknowledged new understandings that were gained from the participants' explanation of their experiences.
- Conducted interviews individually with each participant and noting her feelings and observations during these interviews.
- Focussed on what was happening during interviews as well as what was important in the lives of the participants. However, as Beck (1992:167) remarks,

bracketing does not eliminate perspectives, but it brings the experience into clear focus.

- Remained neutral with respect to the belief or disbelief and right or wrong regarding the experiences and behaviours of student nurses in the clinical learning environment.

## **4.8.2 Transferability**

Transferability refers to the degree to which the findings can be applied to other contexts (Krefting 1991:216). It allows someone *other* than the researcher to determine whether the findings of the study could apply in another setting (Talbot 1995:488). It is thus not the responsibility of the researcher to prove transferability. However, since the present research is conducted primarily for purposes of academic advancement the researcher did, in chapter 7, indicate to which existing theory the present findings relate. In a sense, this represents *transferability*.

### **4.8.2.1 Nominated sample**

A nominated sample refers to the use of a panel of judges to help in the selection of participants experienced in the phenomenon under study (Krefting 1991:220). A nominated sample refers to the use of one or two long time members of a family support group to identify persons who are typical of the membership (Field & Morse 1985 in Krefting 1991:220). The head of the college campus was involved in selecting student nurses with experience of the clinical learning environment. The sampling method included purposive as well as convenience sampling of student nurses from second, third and fourth year levels of academic advancement. Characteristics of the original sample of persons, settings, and processes are fully described in section 4.3.2, to permit adequate comparisons with other samples.

### **4.8.2.2 Dense description**

The researcher provided a detailed database and a dense description of student nurses' experiences of the clinical field as learning experiences. Dense descriptions of the participants' experiences are given in chapter 6.

### **4.8.3 Dependability**

According to Miles and Huberman (1994:278), the underlying issue concerning dependability is whether the process of the study is consistent and reasonably stable over time and across researchers and methods. To ensure rigour in phenomenology one has to ensure that the methodology is consistent with the philosophical base (Rose et al 1995:1126). For this reason the researcher first acquainted herself thoroughly with phenomenology as a philosophy and as a research methodology prior to engaging in this research project.

To overcome inconsistency the exact methods of data gathering, analysis and interpretation of the data are fully described. Chapter 5 gives full descriptions of data analysis. The researcher's role and status within the research site is explicitly detailed. Data were collected across the full range of appropriate settings, times and respondents as suggested by the research question. Coding checks were made, and they showed adequate agreement. Data quality checks were made for bias, deceit and informant knowledgeability. A clear data trail was left should anyone wish to conduct a data audit or conduct secondary analysis of the data.

### **4.8.4 Confirmability**

Confirmability is a strategy used to achieve neutrality. Lincoln and Guba (1985:290) describe neutrality as a criterium used to establish the degree to which the findings of an inquiry are determined by the participants and not by the biases or interests of the enquirer. Bracketing again becomes pertinent.

To ensure confirmability, the researcher's promoter followed the progression of events in the present study to try to understand how decisions were made. According to Lincoln and Guba (1985:290), confirmability can be ensured through auditability, and code-recode procedures.

#### **4.8.4.1 Auditability**

Lincoln and Guba (1985:319) further state that the major technique for establishing confirmability is by means of an audit technique for which an audit trail must be left.

Auditability of the study was enhanced by adopting Halpern's (1983) (in Lincoln & Guba 1985:319) suggestion for creating an audit trail. The following were kept:

- Raw data, including audiotape records and field notes.
- Data reduction and analysis products, such as summaries of such condensed notes.
- Process notes, such as methodological notes, as well as trustworthiness notes.
- Interview guide development information.
- A research interview guide was submitted to the research experts for evaluation.

In addition, the reader will find that every data unit in the data analysis and presentation section (chapter 5) is accompanied by a numerical code. These codes indicate the sequence of evidence within the original transcripts. This facilitates locating data units (evidence) and reading these in the context of the original transcripts should the need arise.

#### ***4.8.4.2 Code-recode procedure***

A code-recode procedure was involved in consensus discussion between the researcher and independent experts. The study's general methods and procedures were described in detail. The actual and detailed sequence of data collection, analysis and transformation were followed. All categories and themes, up to the present final product, were considered tentative and open to recoding and restructuring, to arrive at the most acceptable and complete description of the object of intention.

## **4.9 CONCLUSION**

Chapter 4 gave a detailed explication of the operationalisation of phenomenology via a qualitative research design. Sampling, data gathering and the ethics involved in the research, with special reference to trustworthiness through bracketing, are discussed in detail. This discussion proceeds in chapter 5 where the processes involved in data analysis are detailed.

## Chapter 5

### Data analysis

#### 5.1 INTRODUCTION

Qualitative data analysis is a process of organising data into its constituent components, to reveal its characteristic elements or structure (Dey 1993:31) and to impose order on a large body of unstructured information (data) so that general conclusions can be reached and can be communicated in the research report (Polit & Hungler 1993:329). This is a relatively systematic process of selecting, categorising, comparing, synthesising, and interpreting data to provide explanations of the phenomenon of interest (MacMillan & Schumacher 2001:462) that requires researchers to dwell with or become immersed in the data (Streubert & Carpenter 1999:60).

The data analysed during the present study were obtained through in-depth interviews (see chapter 4) resulting from the research question:

- **How do you experience the clinical field as learning field?**

Alternatively:

- **How do you experience learning in the clinical fields?**

The transcriptions of interviews became the raw data for analysis. Within the broader parameters of qualitative data analysis, each transcript of participants' oral descriptions of their experiences of learning was analysed using Wertz's (1983, 1984, 1985) empirical psychological reflection (EPR) approach in phenomenological studies.

#### 5.2 GENERAL PRINCIPLES IN QUALITATIVE DATA ANALYSIS

Streubert and Carpenter (1999:28) point out that qualitative data analysis begins simultaneously with data collection whereby researchers keep, and constantly review, data to discover additional questions or descriptions of their findings while conducting interviews or observations. According to McMillan and Schumacher (2001:462), *discovery analysis* strategies are used to develop tentative and preliminary ideas during data collection. In addition, Miles and Huberman (1994:10) are of the opinion that during

the analysis of qualitative data, researchers reduce data throughout the process. These authors refer to data reduction as the process of *selecting, focusing, simplifying, abstracting* and *transforming* the data (see section 2.6.4) that appear in compiled field notes or transcripts. The final result hereof is clusters of ideas referred to as *themes*, which give structure to data (Streubert & Carpenter 1999:28), aiding in discovering the meanings inherent in what was observed and heard. Meaning and understanding are further arrived at by reading, rereading, and reflecting upon the significant statements in the original transcripts. Streubert and Carpenter (1999:28) assert that once researchers have explicated all themes relevant to a study, they write it up in a way that is meaningful to the intended audience.

The above issues are usually covered through the general sequence of events in qualitative data analysis as summarised by Tesch (1990:95-97) namely:

- conducting an analysis systematically and comprehensively, but not rigidly, which proceeded in an orderly fashion, disciplined, and in an organised mind, characterised by willpower
- attending to data, which included an introspective activity that results in a set of analytical notes that direct the process
- segmenting data, in other words, dividing data into relevant and meaningful units, started by reading through all the raw data to achieve 'a sense of the whole' in order to fertilise the interpretation of individual data pieces
- 'interrogating' parts of the data with regards to content items and themes forming categories
- using the method of comparing and contrasting during analysis: forming categories, establishing the boundaries of these categories, assigning data segments to categories, summarising the content of each category, finding negative evidence; all done to discern conceptual similarities, to refine the discriminative power of categories, so as to discover patterns within the data

- ensuring that categories for sorting segments are tentative and preliminary in the beginning, and that they remain flexible

Tesch's explication, and those of the other authors referred to do, however, not put in the picture the mental operations involved in qualitative data analysis; though understanding these are of the utmost importance in qualitative research in general and in phenomenological research in particular. For this reason the researcher turned to the work of phenomenologists from the Duquesne tradition (Van der Wal 1999), more specifically the work of Wertz (1983a, 1983b, 1984 and 1985), to prepare herself for data analysis.

### **5.3 OVERVIEW OF THE FUNDAMENTALS OF PHENOMENOLOGICAL DATA ANALYSIS**

Phenomenologists, Van Kaam (1966), Giorgi (1975), Colaizzi (1978) and Wertz (1983a) shared the common goal of describing the essential structure of phenomena as depicted by table 5.1. The reader might be puzzled by the fact that these summaries on data analysis include the whole research process as explicated by these phenomenologists individually. The reason is, as Streubert and Carpenter (1999:28) point out that qualitative data analysis begins simultaneously with data collection whereby researchers keep, and constantly review, data to discover additional questions or descriptions of their findings while conducting interviews or observations.

**TABLE 5.1**  
**SUMMARY OF DATA ANALYSIS ACCORDING TO THE APPROACHES OF VAN KAAM (1966), GIORGI (1975), COLAIZZI (1978) AND WERTZ (1983)**  
 (Adapted from Van der Wal (1999:366-367) with permission)

<b>STEP</b>	<b>VAN KAAM (1966)</b>	<b>GIORGI (1975)</b>	<b>COLAIZZI (1978)</b>	<b>WERTZ (1983)</b>
1	Problem and question formulation: the phenomenon	The researcher reads the entire description straight through to get a sense of the whole	Discovering a fundamental structure (FS) of the individual Phenomenological reflection (IPR).	Problem and question formulation: The phenomenon. <ul style="list-style-type: none"> <li>• Identify and name the phenomenon</li> <li>• State a "hypothesis" or research question</li> </ul>
2	Data generation situation: collecting descriptions	The researcher reads the same description more slowly and delineates each time where a transition in meaning is perceived with respect to the intention of discovering the meaning of the phenomenon	Obtaining a fundamental description (FD) of the phenomenon by means of phenomenal study (PS). <ol style="list-style-type: none"> <li>1. Consider all statements with respect to their significance</li> <li>2. Eliminate all repetitive statements</li> <li>3. Classify all relevant statements into natural categories</li> <li>4. Reformulate raw statements into succinct expressions</li> <li>5. Arrange components into series of statements accepted by the FD of the phenomenon obtained by PS</li> </ol>	Data generation situation: The protocol of life text: - Obtaining a descriptive narrative of the lived experience. - Experiences are queried and dialogue is developed.
3	The presentation of the results and final formulation	The researcher reflects on the given constituents still expressing essentially in the concrete language of the participant. Transference from colloquial language of the participant to the language of psychology.	Discovering a fundamental of the individual phenomenological reflection (IPR).	Presentation of the results and formulations
3		The researcher synthesises and integrates the insights achieved into a consistent description of the structure of the phenomenon. The structure is communicated to other researchers for the purpose of confirmation or criticism.		

## **5.4 THE PROCESS OF DATA ANALYSIS ADHERED TO DURING THE PRESENT RESEARCH**

Data analysis of the current study was conducted through using Wertz's (1983) approach. The researcher was motivated by Streubert Speziale and Carpenter's (2003:56) statement that to really understand qualitative research in general and phenomenology specifically, prospective researchers need to return to the original work during the "high days" of a specific methodology and to the philosophical underpinnings of this type of research. In addition, among the Duquesne phenomenologists Wertz (1983, 1985) was selected as he is the more recent researcher of the founding group; his work is consequently reflective of aspects of his predecessors.

The Empirical Psychological Reflection (EPR) conducted by Wertz's (1983a, 1985) approach is discussed under the following:

- Branches of empirical psychological reflection
- The process of empirical psychological reflection

### **5.4.1 Branches of empirical psychological reflection**

Von Eckartsberg (1986:23) (in Van der Wal 1999:338) outlines Empirical Existential Phenomenology from which EPR is interpreted into three distinct branches. These were also applied during the present study:

- Research in terms of structural orientation, which aims at revealing the essential general meaning structure of the given phenomenon in answer to the implicit guiding research question (What are the experiences of the clinical field as a learning field?). Chapter 6 of this report contains the results of this branch of the researcher's empirical psychological reflection .
- Research focusing primarily on the articulation of the process of human experience, which during the present research answered the question: How do you feel about the experiences? The results hereof are also contained as a sub-category in section 6.3 of this thesis.

- Research using concrete descriptions of experiences as data to critically examine and validate phenomenological constructs, using focussed experiential research to illustrate the usefulness of phenomenological constitution. This is what the whole research project aimed at. In addition, the “usefulness” of phenomenological constitution, the lived experience of student nurses in the clinical learning field, was related to existing theory (see chapter 7).

#### **5.4.2 The process of empirical psychological reflection**

The process of empirical psychological reflection is discussed according to Wertz’s (1983a, 1984, 1985) work and qualified with aspects from other more contemporary authors’ work. The latter is substantiated by the fact that contemporary theory is usually based on earlier theory and often involves semantic differences rather than foundational operational differences. As Tesch (1990:96) indicates, qualitative data analysis and research procedures are “neither ‘scientific’ nor ‘mechanistic.’” In addition, the emergent nature of qualitative research also allows for variations.

##### **5.4.2.1 Data constitution**

Data constitution, the foundation of qualitative research, provides raw (unstructured) descriptive data (Wertz 1985:162). In the context of the present study, the researcher gathered data using open formal phenomenological interviews, which were transcribed *verbatim*. The process of how these interviews were conducted is discussed in section 4.5.1.4.

##### **5.4.2.2 Data handling**

During this phase, raw data were transformed into *individual* phenomenological descriptions as explained in section 4.4.1. To comply with this *individuality* the researcher kept together individual experiences. Initial interviews, after having been analysed, were returned to the participant for clarification and follow-up interviews. The researcher read the interview openly, demarcated the meaning units in the interview, and judged which constituents were relevant. Wertz (1984:40) suggests that at this point the interview data should be re-described in the first person. However, Wertz (1984:40) also points out that the grouping of data may be different for a researcher interested in

preserving the integrity of each individual according to distinct themes. During the present research the first person rewritings were not conducted and consequently individual psychological profiles of students as such were not compiled. The reason for this is that although each participant's experience was analysed individually (ideographically) and follow-up interviews were conducted based on the analysis of previous interviews, too little variation appeared in student experiences to justify individual rewritings. The reason for this could be that peer pressure was strong and "student gossip" influential. However, this is the researcher's inference and the issue deserves further investigation as this might have significant methodological implications for further studies in this area. Nonetheless, the initial data analysis is idiographic in nature.

#### **5.4.2.3 Data analysis (sense making)**

According to Wertz (1983a:198), the researcher finds and makes sense of data at the same time. This operation is enhanced through an open-dialectic between the researcher's specific psychological reflection and the *naïve* description of the participant, in which, the collaborative meaning for each other construct an original (new) understanding of the phenomenon.

Sense making involves:

- The general stance of the researcher.
- The active operation of empirical reflection, involving the individual (*idiographic* phase) and the general (*nomothetic*) phase of data analysis.

The *general stance* of the researcher relates to bracketing and the active *operation* of empirical reflection to the essence of the researcher as *the main instrument* in qualitative research. For this to occur, data should be made accessible, as raw qualitative data are not generally easily accessible (Clifford 1997:134). However, Clifford (1997:134) also cautions that listening to tape recordings of interviews repeatedly might be time consuming. Transcribing taped recorded data allowed the research to "linger" longer and easier with the written data, which further eased analysis. During the present research, data were transcribed using a word processing package as explained in section 5.5. This process clearly indicates the researcher's

treatment of data at both the idiographic and nomothetic levels of analysis. These can be equated to the contemporary use of terms such as open coding and categorisation.

#### **5.4.2.3.1 *The idiographic (specific) level of analysis***

The idiographic (specific) level of analysis is described by Wertz (1983a:199-227) as follows:

##### **5.4.2.3.1.1 *The individual phenomenal description (IPD)***

Individual phenomenal description of the phenomenon refers to the single person's expression of the matter to be studied with all irrelevant statements excluded (Wertz 1983a:199). The term "idiographic" derives from the Greek word "idio" meaning "self" and "graphy" meaning "writing or talking" (Mautner 2000). Thus, talking or writing about one self within the context of the present research this "writing about self" figures in the interview conversation, the tape recordings and the transcripts.

The individual phenomenological description represents the *naïve* everyday account of a single person of the event under study (Wertz 1983a:198). This is the researcher's entry point to the situation in order to achieve knowledge, understanding and insight.

##### **5.4.2.3.1.2 *Compiling a psychological analysis of the individual (PAI) from the IPD***

The limit of the individual phenomenal description as part of the idiographic phase of analysis is that the psychology of learning in the clinical learning field has not been expressed yet. In this instance, psychology does not refer to the discipline of psychology but to the psychological intelligibility of the individual experience of the phenomenon. This forms the essence of this phase, during which the researcher arrives at an understanding of an individuals' experience: This involves the researcher's understanding of:

- The imminent signification of the situation(s) in which student nurses participate.
- The structural identity in the single case; the interrelation of imminent meanings (Wertz 1983a:203; 1985:173) as applied in chapter 6.

In this phase, the researcher reread every individual phenomenal description and thought it through psychologically. The findings were expressed in a way most typical of a particular case, or as Wertz (1983a:204) calls it, as an Individual Psychological Structure (IPS).

According to Wertz (1983a:204), within the idiographic level of analysis, five *components* of the *researcher's basic stance* or attitude towards the everyday description; and eleven *operations*, out of which psychological insights emerged in the research, were differentiated. This is a very complex process (Wertz 1985:173) as the researcher both *finds and makes* sense, pertaining to the phenomenon under study, at the same time. The present researcher, however, benefited greatly by having acquainted herself with these five components and eleven processes as these reassured her that she was on the right track and improved her understanding of personal experiences during the research.

#### 5.4.2.3.1.3 *The general stance of the research*

- **Empathetic immersion in the world of description**

In empathetic immersion in the world of description, the researcher used the verbatim transcript as a point of access from which to make the participant's living situations her own. According to Wertz (1983a:204), the researcher cannot be a spectator but must experience the joys and pains of his/her participants in full detail and in depth if he/she is to faithfully know them. Therefore, this author considers this aspect of the attitude as an essential basis for reflection.

During the present study, the researcher had to place herself in the clinical learning environments, physically and imaginatively. Using each participant's description of the lived experiences of the clinical field as learning field helped her to reconstruct the student nurse's situation in a fundamental way and prepared her to reflect accurately upon these individual instances of the phenomenon.

- **Slowing down and dwelling**

The researcher did not pass over the details of the description at any point as if they were already understood. Instead the researcher made room for the participant's description and allowed herself time to come to an understanding of the participants' lived experiences. During in-depth interviews, the researcher slowed down, lingered, and dwelled, by using probing questions. Wertz (1983a:200) warns that if the researcher simply passes over incidents, its meaning would remain largely implicit. Wertz (1983a:205) advises researchers to slow down, linger, reflect, and reread to make the meaning of each meaning unit explicit. At this point, it can be indicated that this is very time consuming and that the researcher's opinion is that if this is not done, even though time consuming, the quality of data analysis might be compromised.

- **Magnification and amplification of the situation**

According to Wertz (1983a:205), when the researcher stops and lingers with something, its significance becomes magnified or amplified. What, to the participant or a naïve reader, seems unimportant and mundane could be quite significant to the researcher. Therefore, the researcher must transcend the mundane issues of the participant's situation. This, during the present research finally took shape as the researcher related the findings of the present research with existing theory from different disciplines (see chapter 7).

- **Suspension of belief and employment of intense interest**

According to Wertz (1983a:206), this is a modification of natural and naïve empathy through which the researcher originally entered the participant's situation. There is a distinct relationship between *suspension of belief* and *bracketing* as discussed in section 4.8.5.1 .

Breaking the fusion with the participant, the researcher reflects and thinks interestedly about where the participant finds him/herself in time and space, how he/she got there, and what it means to be there. When the researcher ceases to be absorbed in the participant's world in the mode of naïve belief, no judgement of the truth or falsifying of the experience should be done. The researcher should become interested in the

specific constitutive processes in which the participant plays a part. According to Wertz (1983a:206), the researcher must free him/herself from the participant's immediate experience to see its origin, relations, and overall individual structure.

- **The turning from objects to their meaning**

Wertz (1983a:206) states that during this process, the researcher is not concerned about the reality or unreality of the objects or state of affairs described by the participant. The researcher turns his/her attention from facts to their meanings. During the present study, the researcher was interested in the meaning the “fact of learning in the clinical field” had for participants. The researcher focused only when a student nurse experiences learning and adheres to what really happened precisely as the student nurse relates the lived meaning to her. For example, if a student nurse says: “That day I had a lot of activities to do, this also include compiling nursing care plans, and responding to what the patient wants, checking progress of patients and of course doing basic routine (Data: 51)”. The researcher in the present study viewed this description as a good experiential hint of a student nurse's being in the world. Therefore, to follow this experience up, the researcher had to ask follow up questions such as: “How did you feel about this experience when it was happening?” and “What does having a lot of activities mean to you as a student nurse?” This kind of probing questions puts one in the realm of the psychological.

#### *5.4.2.3.1.4 Various mental activities during psychological reflection*

Based on the general orientation, the researcher engaged in a number of more specialised mental activities during data analysis as described in the following paragraphs. Wertz (1983a:206) states that these activities are only distinguishable at the theoretical level. These operations relate to contemporary literature on qualitative research in general as reflected in chapter 3 and data analysis as discussed in chapter 6. For instance, during data analysis under the category “correlate theory to practice”, the researcher related this category to the work of Massarweh (1999:44), Tanner (2002:51) as well as Bezuidenhout (2003:19) as indicated in section 6.2.2.3.

During the actual research, these activities overlap and are mutually implicating, constituting an inextricable unity. Ideally all of these operations, either successively, in

combinations, or in an all-in-once strokes, would be called into play by every single statement contained in the individual phenomenal description. These activities include:

- **Utilisation of an “existential baseline”**

According to Wertz (1983a:207), implicit in the researcher’s frame of reference are the norms of psychological existence; typical day-to-day life in which the phenomenon under study is not profoundly present or in which the phenomenon predominates. This serves as the ground upon which the phenomenon under study stands out and is identified. With reference to the present research, such an existential baseline is the assumption that *the essence of being is to learn and reflect constantly on present situations in terms of what was previously experienced (learned)*. The clinical learning field though an intentional learning field does, however, not differ from everyday life. Though every moment does not entail intentional professional learning, it constitutes learning in terms of the existential base-line; the individual learns (experiences) continuously.

- **Reflection on judgment**

According to Wertz (1983a:207), reflection and judgement are continuously in play during data analysis. In the opinion of the present researcher, in line with the set existential base-line this is true of everyday living too. The researcher judged the statements in the individual phenomenal descriptions for relevancy to the phenomenon under investigation. This the researcher also did to reflect on her personal judgement by asking herself questions such as: “How do I understand the student nurses’ lived experiences of the clinical field?” “What does this statement reveal about clinical learning? How and why is it relevant or irrelevant?”

- **Penetration of implicit horizons**

It should be noted that the descriptions or transcripts themselves are not the ultimate objects of reflection despite their necessity in this regard. Reflection ultimately addresses the participant’s participation in “immanent signification,” which make up this lived reality of the participant. According to Wertz (1983a:207), once the researcher (by way of access) is firmly situated in the participant’s world, the researcher can reflect on

things not mentioned through the description but demonstrably present, even if highly significant but implicit in the participant's living. In this regard, the researcher's experience as a nurse educator in the clinical field was of unquestionable value.

- **Making distinctions**

Wertz (1983a:208) states that once the researcher is fully involved in the participant's situations, many kinds of distinctions are made. The researcher finds himself or herself able to see different *constituents* of the phenomenon under study and patterns, themes and categories become apparent. Themes and categories are reflected in chapter 6.

- **Seeing relations of constituents**

According to Wertz (1983a:208) researchers have to address each distinguished constituent or statement, by reflection on what it has to do with other elements and statements? For example, during interviews the researcher asked probing questions such as: How does that influence your learning? In thinking, through the togetherness and relations of constituents in terms of temporality, space, social aspects and the like, the researcher sees relative priorities. Some aspects of the phenomenon inevitably appear to depend upon or presuppose, others. Wertz (1983a:209) points out that, during this phase, the researcher looks for unity and consistency of diverse experiences.

- **Thematisation of recurrent meanings or motifs**

Closely related to the abovementioned procedure, the researcher looked for the unity and consistency of diverse student nurses' experiences of the clinical field as learning field. For example, the theme on motivational factors in the clinical field is seen in the original experience of praise, availability of nurse educators and cooperative learning as exhibited in table 5.2.

<b>TABLE 5.2</b>
<b>THEME 3: MOTIVATIONAL FACTORS IN CLINICAL LEARNING: OVERVIEW (6.3)</b>
Praise as a potential motivator (Data display: 6.3.1)
Availability of nurse educators (Data display: 6.3.2)
Cooperative learning (Data display: 6.3.3)
▪ Information exchange (6.3.3.1)
▪ Problem-solving (6.3.3.2)
▪ Practising procedures (6.3.3.3)
▪ Self-evaluation (6.3.3.4)
▪ Discussion (6.3.3.5)

According to Wertz (1983a:209), the seeing of these themes is an incipient presence to essential aspects of the case under consideration.

- **Interrogation of opacity**

In analysing data, there are always vague areas, which perplex the researcher. Often sense is created by dwelling with special persistence in these areas and interrogating their context (Wertz 1983a:209). For instance, when the student nurse explains her worst experience as having to work long hours of night duty from 19:00 until 07:00, without having been given any information (briefing) on the experience, the participant was questioned regarding how she actually experiences twelve hour shifts; what it does to her learning; what she learned experientially from these shifts, what she learns about herself, her authentic self, in the clinical situation. All these issues were probed to interrogate opacity.

- **Imaginative variation and seeing the essence of the case**

The researcher asked whether any of the constituents, distinctions, phases, relations, and themes could be different or even absent while still presenting the individual's psychological reality. For instance, a student nurse explained that it is important that tutors actually go into the ward because if student nurses see them coming they become motivated to learn. If tutors were not available in the clinical field, would they have experienced any learning or not? The researcher asked the student nurse "Why?" and "What experience does this elicit?" By varying each aspect of the experience through questioning, the researcher ascertained what could be involved in the peculiar character of the individual student nurse's experience. The researcher is convinced that this exercise is less "imaginative" than what earlier phenomenologists did and perhaps,

for this reason, more acceptable. “Unique individual psychological profiles” as applied by Van der Wal (1999:366-382) could also have been used had individual phenomenal description being compiled during the present research.

- **Languaging**

“Languaging” refers to the researcher’s attempts to express the sense he/she is finding during the idiographic phase (Wertz 1983a:210). Themes, phrases, distinctions and relations are all named, *languaged* with the goal of developing psychological descriptions. Wertz (1983a:199) points out that in this regard, psychological reflection and sense does not arise on a groundless base or come out of nowhere. Its point of departure is the description in everyday language of an event in the participant’s life and lived world. Thus, the results of this phase are no longer expressed strictly in the participant’s own words but in that of the researcher, since it is in part his or her psychological reflection that is being expressed (Wertz 1983a:210). “Interpretation” becomes inevitable, as the research does not work from a clean slate. Thus the general concept of *bracketing* was always kept in mind by the researcher during *languaging*.

- **Verification, modification, and reformulation**

Wertz (1983a:210) states that whenever the researcher speaks in psychological terms, there is a distance between what is said and the participant’s original description. Hence, the danger exists of the researcher losing contact with the participant’s lived situation. This was avoided during the present research by constantly comparing the reflective statements with the original descriptions in order to verify, modify or negate newly emerging reflections coming to the researcher. As it becomes increasingly difficult to maintain this type of contact as the study progresses and conceptualisation on the part of the researcher becomes increasingly “psychological” and “theoretical,” the sequential numerical codes the researcher ascribed to each and every data unit or piece of evidence (audit trails) greatly eased the process of returning to the original transcripts and reading the data units in context.

- **Using existential-phenomenological concepts to guide reflection**

Wertz (1983b:44) also refers to this phase as *conceptually guided reflection*. This operation is subsequent to verification, modification and reformulation. The researcher might use a general theoretical concept to guide thinking about the case (Wertz 1983a:211). However, some of the concepts embedded in existential phenomenology were used. Examples of these concepts include: being, life-world, being-in-the-world, lived experience, meaning, multiple realities, *thrownness* as well as other concepts as depicted in table 2.2. In a sense these concepts are so fundamental that the researcher could not “bracket” these, as such an exercise would nullify existence itself. Nevertheless, conceptual guidance should facilitate true discovery and uncontaminated contact with a phenomenon rather than replacing it (Wertz 1983a 210). So, whenever any of these concepts were asserted by participants the researcher was alerted and reflected on how other related concepts might be involved. The insight that the researcher gathered in reading about phenomenology (chapter 2) assisted significantly in her understanding of this complex exercise.

#### **5.4.2.3.2 The nomothetic (general) level of analysis**

According to Wertz (1983a:228), the limitation of the individual psychological structure, and consequently that of idiographic analysis, is that it reflects only an individual instance, or an individuals’ stance, of the phenomenon. Individual instances are exactly that, individual instances of a larger phenomenon or multiple realities within “reality.” It should, however, be noted that the movement from individuality to generality does not correspond with the movement from naïve everyday description by participants to researcher constructed psychological structure.

The movement from the everyday to the psychological has already been achieved during the idiographic phase. Therefore the nomothetic phase of analysis is based on the idiographic phase. In terms of the present research, this is a move from the psychology of individual learning in the clinical field to the psychology of learning in the clinical field in general. The goal of the nomothetic phase of analysis is arriving at a general psychological structure (Wertz 1983a:228). This structure attempts to integrate a great diversity of examples. Reciprocally, this achievement involves understanding diverse individual cases as individual instances of something more general and

articulating this generality of which they are particular instances (Wertz 1983a:228; 1983b:46). It thus seems that, in contemporary grounded theory terms, idiographic analysis relates to open coding and description, and nomothetic analysis to axial coding as indicated by Strauss and Corbin (1990:61, 96).

#### 5.4.2.3.2.1 *Procedures for nomothetic analysis*

As this phase is built on the idiographic phase of data analysis, it also involves most the intellectual processes described during the explication of the idiographic phase; originating on the achievements of the previous, idiographic, phase. However, there are also procedures pertinent to the integrative character of the nomothetic phase.

- **Noticing general patterns in individual structures**

Through noticing general patterns among individual psychological structure, Wertz (1983a:228) asserts, the findings of the idiographic phase can become applicable beyond the original context in which they were uncovered and could pertain to many individuals. In addition, the general meaning words have within a certain language and the meaning attached to words also facilitate the process of nomothetic analysis.

Patterns started appearing once the researcher started rereading the individual psychological structures, which no longer could be defined as *raw* data. Rather than taking statements as referring to the particular case, statements were taken as referring to all cases. In doing this, the researcher realised that some statements about the participants' experiences were applicable to general contexts, others were not, and still others were equivocal and required further reflection.

- **Comparisons of individual descriptions**

Rather than uncritically assuming that any statement in the individual psychological structure would be true for all cases, the researcher needed to actually find evidence for this (Wertz 1983a:230). In this instance the researcher compare each individual's psychological structure to all the others and established convergences and divergences. According to Wertz (1983a), the convergences or similarities, when *language*d, are general statements, which may become a part of the general psychological structures of

the phenomenon. The divergences manifest atypical or idiosyncratic structural elements (Wertz 1983a:230).

For instance, the comparisons included the before and after learning, during these comparisons, questions such as: “how does it influence learning? Or “what do you learn from the situation?” were asked.

During the present study, the researcher placed several of the full case analyses in front of her and posed first the most general question: “What is the most obvious similarities among these individual profiles?” This resulted in a very focussed rereading of the profiles. Then the more particular question was asked namely: “What about each of the temporal sub-unities is similar?” Thus, asking for further specificity, a tighter fit of the general statements relating to the phenomenon being investigated was formed. During the present study, the researcher continued to reflectively interrogate the original descriptions while striving for the most specific and precise general insights.

- **Imaginative variation**

To achieve the desired generality, that is, a generality even beyond the actual cases to which the researcher had access through the descriptions, imaginative variation was again employed.

In this instance Wertz (1983a:232) states that imaginative variation helps the researcher to clarify limits within which general statements hold true. During the present study, the researcher carefully studied concrete examples supplied by student nurses' experiences. For example, in articulating the general formulations, the researcher imagined many kinds of motivations, erosive factors and shared lived experiences to see if the general psychology would hold true for these instances. For example, the researcher could not imagine an instance of praise without motivational effect, or an instance of resentment without being erosive to learning in the clinical field. The outcome of imaginative variation led to modification of general understanding. It also revealed a phenomenon other than the one under study; and led to the recognition of kinds of factors that promote learning in the clinical field. The literature support also contributed towards “imaginative” variation.

- **Explicit formulation of generality.**

Based on the steps outlined in Wertz (1983a:235) the researcher had to language the general truths that were noticed. The researcher formulated the essential and the sufficient conditions, constituents, and structural relations, which constituted the phenomenon in general; that is, in all instances of the phenomenon under consideration. According to Wertz (1983a:235), the researcher needs to critically reflect on statements. An example of such reflection includes questions such as:

- “Can we have this phenomenon without this, and this and this?” If the answer, as evident in the empirical data or imaginative variation, was “no” then the statement expressed was necessary to the phenomenon. If “yes”, it was unnecessary and had to be dropped from the general formulation. This does not mean that the researcher is limited to presenting the reader with a single statement or piece of evidence. On the contrary, to comply with the principle of “thick descriptions” in phenomenological and qualitative research, numerous statements on the same aspect of the phenomenon under investigation is called for. The data presentation in chapter 6 attests hereto.
- “Do we have the whole phenomenon?” If the answer was “yes,” then the formulation was sufficient, and if “no,” it was not sufficient and more statements or evidence had to be included so as to reveal the whole phenomenon.

## **5.5 DATA ANALYSIS PROCEDURE AS PER WORD PROCESSOR**

Using a word processing package to analyse qualitative data, though more laborious than using a qualitative data analysis package, has the advantage that it does not require any additional computer skills than those the individual has, if he or she can run a specific word processing package. In addition, data units or evidences are not “hidden away.” Every time the researcher demarcated a new data unit or piece of evidence, and whenever copying these to categories as they were constructed, the researcher became aware of previous additions to categories. This, in a way, also represents “rereading” and this contributed positively to the researcher becoming thoroughly acquainted with the data.

This data analysis entails four phases. Every phase also involves the opening of a new document. In line with the idiographic phase of data analysis, phases 1 and 2 were documented sequentially as were follow-up interviews. This, for instance resulted in a series of documents on one participant. Participant A, transcription of first interview: FILE: A.1.wpd. The initial analysis during phase 2 resulted in document: FILE: A.2.wpd. The follow up transcript resulted in: FILE: A.3.wpd and the analysis hereof in: FILE: A.4.wpd, and so forth. These were also sequentially numbered and files in a data supplement for purposes of auditing and for providing an audit trail.

### 5.5.1 Phase 1: Preparation of the data

During this phase the interview data were transcribed verbatim. This was done in plain text format as indicated in table 5.3.

<b>TABLE 5.3</b> <b>AN EXAMPLE OF PLAIN TEXT</b> <b>(VERBATIM TRANSCRIPTION)</b> <b>(Participant code: A.1)</b>
<p><b>Informant:</b> I was with one of my colleagues in the ward, sister in charge, the other sister, one enrolled nurse, and an enrolled nursing assistant. As I came to the ward in the morning, the night nurse was already waiting to give the report about patients. When I was waiting to get a full report about patients, my expectation was to continue taking care of patients from the ward where the night nurses were.</p> <p><b>Interviewer:</b> How did you experience this in terms of learning?            I have learned to act together with other team members as nurses. I have also gained knowledge about reading the patient's file and relate it to what I see with my eyes in connection with the patient's illness, signs and symptoms and response to medications or care. As the night nurse enters the first ward she tells me that all patients are chronically ill; in the second ward she said no problem all slept well, referring to patients who complained as that one. There was no opening of patient's file to address the patients' condition appropriately.</p> <p><b>Interviewer:</b> How did this make you feel?  <b>Informant:</b> As I was expecting her go patient by patient and tell us what was wrong with the patient I felt that I was not going to end up learning anything that morning. The reason being that if a person who give us report gives it patient by patient it becomes easy for me as a student to pick up what is wrong with the patient.</p> <p><b>Interviewer:</b> Do you consider this as learning? If so, why? If not, why?</p>

### 5.5.2 Initial open coding (idiographic analysis)

Once an interview was transcribed, a new document was opened and a successive or sequential file name was ascribed to the document. A table was prepared with six columns and as many rows as were needed were later added. The whole transcribed interview was then copied into the first column and analysis was started according to the column headings. This was done in landscape format. Table 5.4 displays an example of idiographic analysis.

<b>TEXT</b>	<b>INDIVIDUAL PSYCHOLOGICAL DESCRIPTION</b>	<b>DATA UNIT</b>	<b>INDIVIDUAL PSYCHOLOGICAL DESCRIPTION: Sub categories</b>	<b>CODES: CATEGORIES</b>	<b>CODES THEMES</b>
(9) I was with one of my colleagues in the ward, sister in charge, the other sister, one enrolled nurse, and an enrolled nursing assistant (9).	(9 ) was with one of my colleagues in the ward, sister in charge, the other sister, one enrolled nurse, and an enrolled nursing assistant	(9) with one of my colleagues in the ward, sister in charge, the other sister, one enrolled nurse, and an enrolled nursing assistant	[2.5.2] Being-in-the-world with others	[2.5] Existential base-line	[2] Lived experience of student nurses
As I came to the ward in the morning, the night nurse was already waiting to give the report about patients (10).	(10) the night nurse was already waiting to give the report	(10) give the report	[1.5.1] The dynamics of the clinical field	[1.5] What is learned	[1] Descriptive overview of clinical learning environment

The numbers in brackets within the text and the two columns next to it, indicate the number of the data unit for purposes of leaving an audit trail. At this point, categories and themes were still very tentative and additions could be made to them. This phase then represents the idiographic phase of analysis.

### **5.5.3 Compiling categories and themes (nomothetic analysis)**

Once all the interviews were conducted, transcribed and analysed, a new document was created. The labels of all initial categories created during the initial analysis were entered in this document. Next each data unit was copied from the initial analysis columns and was placed under the appropriate category label. This represents the beginning of the nomothetic phase of analysis as applied during the present research.

If, during this process the researcher found that a data unit might also fit another category, the unit was copied to that category as well.

Finally, the contents of categories were reread repeatedly. Categories were collapsed, sub-divided, discarded – whatever was needed. During rereading the contents of categories, data units, in the absence of the particular context in which they were spoken, the researcher was better able to judge the clarity of both the category label and the evidence; whether these fitted one another. If, especially after a period of absence from reading the contents of these categories, the researcher found that she could not clearly place the evidence within the category, she reread the evidence within its original context. On doing this she decided whether to “re-cut” the evidence to include either more or less information, or whether to remove it altogether from the category.

### **5.5.4 Final presentation of categories within themes**

After many hours of rereading categories and comparing statements, evidence and categories to each other the researcher finally grouped categories together under broader themes. These are reported on in chapter 6.

## **5.6 CONCLUSION**

In this chapter the data analysis process was discussed. This process was derived from the methods used by Wertz’s (1983a; 1983b; 1984; 1985) and was conducted at both the idiographic and nomothetic level of data analysis. Chapter 6 contains the results of

analysis, which includes themes and categories with specific literature support. Individual statements or evidences are representative of the idiographic level of analysis and themes and categories are representative of the nomothetic level of analysis.

## Chapter 6

### Presentation of data, themes and categories with specific literature support

#### 6.1 INTRODUCTION

In this chapter the analysed data are presented in the form of themes, categories and sub categories containing empirical evidence (data units). The phenomenon under study namely: student nurses' experience of the clinical field as learning field, nomothetically emerged in an assemblage of:

- 4 Main themes
- 16 Categories
- 65 Sub-categories
- 53 Sub-subcategories
- 778 Statements (Data units or evidence)

In presenting the themes, categories and sub-categories, a data display showing the overview of all the themes, categories and subcategories are given at the beginning of each sub-section. A summation of each major category indicates the sub-categories that make up the main category is given. This is followed by a specific category/sub-category in the form of a data display, in which the empirical data (evidences) are displayed. In line with the verbatim nature of data transcription, the “spoken word” is exhibited in these displays; grammar was not amended. In the discussion of the results, relevant data from the literature is included to substantiate the category/sub-category. An overview of the complete data structure follows:

#### **THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING OVERVIEW (6.1)**

The concept “learning” in the clinical field (Data display: 6.1.1)

- Doing the right thing (Data display: 6.1.1.1)
- Learning versus work (Data display: 6.1.1.2)

Benefits of clinical field as learning experience (Data display: 6.1.2)

- Reinforcement of knowledge (Data display: 6.1.2.1)
- An area of “prime” learning (Data display: 6.1.2.2)
- Correlation of theory to practice (Data display: 6.1.2.3)
- Correlate practice to theory (Data display: 6.1.2.4)

- Student nurses' expectations (Data display: 6.1.3)
  - Self expectations (Data display: 6.1.3.1)
  - Expectations and opinions of clinical facilitators (Data display: 6.1.3.2)
    - Positive aspects (6.1.3.2.1)
    - Negative aspects (6.1.3.2.2)
  - Student nurses' perceptions of clinical facilitators' expectations (Data display: 6.1.3.3)
  - Students' expectations from nurse educators (Data display: 6.1.3.4)
  - Being with a clinical tutor (Data display: 6.1.3.5)
  - Expected conduct of clinical facilitators (Data display: 6.1.3.6)
- Teaching strategies emerging from the clinical field (Data display: 6.1.4)
  - Coaching (Data display: 6.1.4.1)
  - Peer support system (Data display: 6.1.4.2)
    - General indicators/Emotional support (6.1.4.2.1)
    - Peer group teaching/Teaching milieu (6.1.4.2.2)
  - Clinical assignment (Data display: 6.1.4.3)
  - Invitational learning (Data display: 6.1.4.4)
  - Clinical supervision (Data display: 6.1.4.5)
  - Questioning and answering (Data display: 6.1.4.6)
    - General indicator (6.1.4.6.1)
    - Questioning and good communication (6.1.4.6.2)
    - Asking questions (6.1.4.6.3)
    - Being questioned (6.1.4.6.4)
    - Questioning as invitational learning (6.1.4.6.5)
    - Negative aspects in asking questions (6.1.4.6.6)
  - Modelling (Data display: 6.1.4.7)
  - Discussions (Data display: 6.1.4.8)
- What is learned (Data display: 6.1.5)
  - The dynamics of the clinical field (Data display: 6.1.5.1)
    - Continuity (6.1.5.1.1)
    - Becoming a team member (6.1.5.1.2)
    - Interpersonal relations (6.1.5.1.3)
    - Ambiguity and uncertainty of the clinical field (6.1.5.1.4)
  - Arts and science autonomy (Data display: 6.1.5.2)
  - Nursing ethics, professionalism and etiquette (Data display: 6.1.5.3)
    - General indicators (6.1.5.3.1)
    - Correcting aspects of personal ethos (6.1.5.3.2)
    - Professionalism and caring ethos (6.1.5.3.3)
  - Caring (Data display: 6.1.5.4)
    - Gentleness (6.1.5.4.1)
    - Caring ethos project (6.1.5.4.2)
    - Dedication (6.1.5.4.3)
    - Relating (6.1.5.5.4)
    - Empathy and authenticity (6.1.5.5.5)
  - Interacting and connecting (Data display: 6.1.5.5)
    - With colleagues (6.1.5.5.1)
    - With patients (6.1.5.5.2)
    - With clinical staff (6.1.5.5.3)
  - Composite skill (Data display: 6.1.5.6)
  - Self-directedness (Data display: 6.1.5.7)
  - Perseverance and "imperviousness" (Data display: 6.1.5.8)
  - Self-knowledge (Data display: 6.1.5.9)
- Sources and resources of knowledge and skills (Data display: 6.1.6)
  - Experienced staff (Data display: 6.1.6.1)
  - Reference materials (Data display: 6.1.6.2)
    - Text books (6.1.6.2.1)
    - Outcomes and objectives (6.1.6.2.2)
    - Guidelines for evaluation (6.1.6.2.3)
    - Workbooks (6.1.6.2.4)
  - Patients as a source of learning (Data display: 6.1.6.3)
    - General indicators (6.1.6.3.1)
    - Maintaining good relationships with patients (6.1.6.3.2)
    - Maintaining what was demonstrated (6.1.6.3.3)

- Knowing patients (6.1.6.3.3)
- Patient attitude (6.1.6.3.4)
- The informed patient (6.1.6.3.5)
- Reciprocation between student and patients (6.1.6.3.6)

## **THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES OVERVIEW (6.2)**

General indicators (Data display: 6.2.1)

- General indicators (6.2.1.1)
- Good clinical experiences (6.2.1.2)
- Bad clinical experiences (6.2.1.3)

Positive experiences (Data display: 6.2.2)

- Positive attitudes (Data display: 6.2.2.1)
- Sources of joy (Data display: 6.2.2.2)
  - General indicators (6.2.2.2.1)
  - Hopefulness (6.2.2.2.2)
  - Overcoming adversity (6.2.2.2.3)
  - Growth (6.2.2.2.4)
  - Success (6.2.2.2.5)
  - Being accepted/belonging (6.2.2.2.6)
- Sense of awareness (Data display: 6.2.2.3)
  - Self-awareness (6.2.2.3.1)
  - Awareness of what is to be known (6.2.2.3.2)
  - Awareness of “nursing” (6.2.2.3.3)
  - Awareness of the clinical environment as learning area (6.2.2.3.4)

Negative experiences (Data display: 6.2.3)

- Isolation (Data display: 6.2.3.1)
- Demoralising (Data display: 6.2.3.2)
- Lingering (Data display: 6.2.3.3)
- Frustration (Data display: 6.2.3.4)
- Copying wrong practices (Data display: 6.2.3.5)
- Being afraid and being frightened (Data display: 6.2.3.6)
  - Being afraid (6.2.3.6.1)
  - Being frightened (6.2.3.6.2)
- Being negated (Data display: 6.2.3.7)
- Non-learning experiences (Data display: 6.2.3.8)

## **THEME 3: MOTIVATIONAL FACTORS IN CLINICAL LEARNING: AWARENESS AND MOTIVATION OVERVIEW (6.3)**

Praise as a potential motivator (Data display: 6.3.1)

Availability of nurse educators (Data display: 6.3.2)

Cooperative learning (Data display: 6.3.3)

- Information exchange (6.3.3.1)
- Problem-solving (6.3.3.2)
- Practising procedures (6.3.3.3)
- Self-evaluation (6.3.3.4)
- Discussion (6.3.3.5)

## **THEME 4: EROSIIVE FACTORS IN CLINICAL LEARNING: AWARENESS OF THE EROSIIVE ASPECT OVERVIEW (6.4)**

Allocation to and in the clinical field (Data display: 6.4.1)

- Group allocation (6.4.1.1)
- Night shift (6.4.1.2)
- Non-specific tasks (6.4.1.3)

Student nurses' attitudinal issues (Data display: 6.4.2)

- Hostility (Data display: 6.4.2.1)
- Lack of the student's personal responsibility (Data display: 6.4.2.2)
- Negative perceptions of trained staff (Data display: 6.4.2.3)
- Retaliation (Data display: 6.4.2.4)
- Status of students in the clinical area (Data display: 6.4.2.5)

Students' perceptions of clinical facilitators (Data display: 6.4.3)

- Being a negative role model (Data display: 6.4.3.1)
- Self-centeredness (Data display: 6.4.3.2)

- Preoccupation with mistakes (Data display: 6.4.3.3)
  - Reflecting upon mistakes (6.4.3.3.1)
  - Labelling student nurses (6.4.3.3.2)
  - Threatening behaviour on the part of the facilitator (6.4.3.3.3)
- Erosive elements in the environment (Data display: 6.4.4)
  - Non-conductive physical environment (Data display: 6.4.4.1)
    - Nurses home (6.4.4.1.1)
    - Hospital environment (6.4.4.1.2)
  - Non-conductive psycho-social environment (6.4.4.2)
  - Inconsistency in the accompaniment of student nurses (Data display: 6.4.4.3)

*(Note that data display numbers are numbering .1 lower than the subparagraph numbers.)*

## **6.2 THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**

According to Streubert (1994:29), clinical learning experience refers to the opportunity of student nurses to apply theoretical learning in the practice setting. The clinical field serves as a context within which student nurses' experiences are interpreted as learning. According to Stokes and Kost (2005:325), clinical experiences refer to all the activities in which students engage in the practice of nursing. Learning from experience, or experiential learning, according to Kolb's (1984) theory, involves concrete experiences, reflective observation, abstract conceptualisation and active experimentation (Quinn 2000:63). Van der Wal (2002:114) defines "experience" as a person's knowledge or skills, based on his/her personal observations, actions and contacts throughout his/her life. The word "experience", as contained in the guiding research question, positioned the participants within the specific context of clinical nursing; a specific part of the lived world of student nurses.

The experiences of students of the clinical field were varied. Participants often described their experiences in terms of the concept learning, student nurses' expectations, benefits of clinical field as learning experiences, teaching strategies emerging from the clinical field, what is learned, sources and resources of knowledge and skills. Data display 6.1 contains a summary of the categories contained in Theme 1: Descriptive overview of clinical learning.

<b>DATA DISPLAY 6.1</b>	
<b>THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING OVERVIEW</b>	
◇	The concept "learning" in the clinical field (Data display: 6.1.1)
◇	Benefits of clinical learning experiences (Data display: 6.1.2)
◇	Student nurses' expectations (Data display: 6.1.3)
◇	Teaching strategies emerging from the clinical field (Data display: 6.1.4)
◇	What is learned (Data display: 6.1.5)
◇	Sources and resources of knowledge and skills (Data display: 6.1.6)

## 6.2.1 The concept “learning” in the clinical field

Of significance to the present study, is the outcome of “learning” in the clinical field. “Learning” is a process through which the learner (student nurse) gains knowledge and skills, which is manifested by change of behaviour, indicating that a person has learnt something or has socialised to a certain extent (Ehlers 2002:3). As people develop and grow, an accumulative reservoir of experience is collected which serves as an expanding source of learning for self and which can be made available to others (Klopper 2000:46). Andresen (“Sa” - Sine anno) gives Kolb’s (1984) definition of learning as the ongoing process through which knowledge is created during the transformation of experience. Furthermore, experiences are transformed both objectively and subjectively into learning, via the full range of internal processes of: willing, remembering, imagining, sensing, intuiting, feeling, and reasoning. Muller (2002:291) corroborates this by stating that learners (student nurses) should analyse the learning content and make it their own so that it will have meaning.

The concept learning in the clinical field, as experienced by student nurses, include doing the right thing and learning versus work. Data display 6.1.1 gives an overview of the concept “learning” within the clinical field as a subsection of the descriptive overview of the clinical field.

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**DATA DISPLAY 6.1.1**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 1: THE CONCEPT “LEARNING” IN THE CLINICAL FIELD**  
**OVERVIEW**

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- ◇ Doing the right thing (Data display: 6.1.1.1)
  - ◇ Learning versus work (Data display: 6.1.1.2)
- 

Experiences as reflected in the data display 6.1.1, demonstrate *experientialism*. Experientialism’s origins can be traced back to Aristotle. Today’s experientialists generally follow Dewey, Lewin and Piaget (as cited in Quinn 2000:62) emphasising first-hand knowledge arising out of direct experience of that which is being studied, via ongoing reflection upon that experience (Doing the right thing and learning versus work). Kolb (1984) stressed that process is more important than outcome in learning, that learning involves “grasping reality” “choosing experiences” and in the process “developing individual learning styles” (preferred ways of engaging with the world and learning from it) (Andresen [Sa]). According to Quinn (2000:62) experiential learning is

learning by doing. Active involvement of the student together with student-centredness, provide a degree of interaction (section 6.2.5.5), and some measure of autonomy and flexibility (section 6.2.5.2). Clinical practica experience provides learning opportunities that enable the achievement of stated learning outcomes and competence in clinical situations (An Bord Altranais 2000:22), through the previously mentioned strategies of grasping reality, choosing experiences and developing individual learning styles.

### **6.2.1.1 *Doing the right thing***

Participants in this study, articulated learning in the clinical field as; “doing the right thing” as well as learning about all the clinical issues that are present in the clinical area. The notion of “doing the right thing” also relates to Deming’s principles of quality improvement (Booyens 1998:601). As pointed out in Booyens (1998), professional practitioners and non-professional workers should develop a positive attitude towards their work, and consider doing things right the first time as a matter of routine to ascertain high standards of quality care.

Therefore, if doing things right, becomes a matter of routine in the clinical field, each experience of “doing” reinforces practice. Consequently learning in the clinical field in a sense would involve *conditioning* as learning theory (Quinn 2000:111-114).

The need for student nurses to be assertive and being accurate is associated with doing the right things. “Things” in the context of this study, include all activities that occur within the clinical field. Much as learning in the clinical field is articulated with doing the right “thing,” it was also noted that if “things” are done wrongly, this can not be considered learning. In addition, it was experienced that no learning occurred when student nurses performed procedures without guidance. These activities include procedures, attitudes, and administrative issues. This becomes evident when one participant indicated that:

Learning according to me, is learning how to do the right thing, if I learn to do things wrongly that is not learning (Data:33).

Based on the existential base-line set for this research, the informant’s statement does not hold “true” as the essence of life and living, of experience is learning. With regards to “wrong” learning, the process of “unlearning” and “relearning” becomes important.

Examples of statements on “doing the right thing” as constituting learning within the clinical field, are reflected in data display 6.1.1.1.

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**DATA DISPLAY 6.1.1.1**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 1: THE CONCEPT “LEARNING” IN CLINICAL FIELD**  
**SUB-CATEGORY 1: DOING THE RIGHT THING**

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- ◇ Learning according to me, is learning how to do the right thing, if I learn to do things wrongly that is not learning (Data:33).
- ◇ I should be assertive and correct in the situation by keeping on doing or saying the right thing (Data:37).
- ◇ ...and it (learning) means that what is being done has been proven to be correct (Data:145).
- ◇ Clinical learning is learning about all clinical issues, procedures, attitudes, administration, I mean everything that is there and doing these things right (Data:147).
- ◇ . . . I didn't understand and that was a problem because doing things on my own without understanding made me to feel that I will get used to wrong procedures (Data:480).
- ◇ It --- because at the end of the year when you do an OSCI, they expect us to do the right thing not what it should be done in the ward (Data:756).

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Doing the right thing and doing things right has definite ethical and professional implications. As Chinn and Kramer (1999:26) indicate, duty was often, prior to the 1950's, expressed in religious admonition to “love”, to “live right”, and to have faith. In a sense all of these correlate with nursing ethics and professionalism as explained in section 6.2.5.3, and in addition correlate with “doing the right thing” and “doing things right” and learning in the clinical field. It is, however, alarming that “doing the right thing” sometimes implies a theory and practice dissociation as indicated by the statement that:

It --- because at the end of the year when you do an OSCI, they expect us to do the right thing not what is done in the wards (Data:756).

This issue is taken up again in section 6.2.4 on “correlation of theory and practice.”

An important issue in clinical learning and “doing the right thing” is assertiveness of the student nurse (also see section 6.2.5.7). As one participant (student) indicated:

I should be assertive and correct in the situation by keeping on doing or saying the right thing (Data:37).

Assertive nurses, according to Swansburg (1993:362), stand up for their rights, while recognising those of others, being straight forward, as well as being free to be responsible and consequently doing the right thing. According to Mellish, Brink and

Paton (1998:311), assertiveness is a skill, which must be learned, just like any other behavioural skill. Assertiveness training can help student nurses to develop skilful ways of handling conflict, reducing stress and anxiety in handling social situations, improving one's self image, promoting more positive feelings about oneself and actions indicative of personal growth (Mellish et al 1998:314) as well as doing the right things.

Dickerson, Neary and Hyche-Johnson (2000:192) found that the Native American student nurses were insightful about their perspectives and recognised the need for change in themselves, which included obtaining a professional presence that is assertive. Such professional presence, however, also stems from doing the right thing, doing things right and trusting oneself in this. The respondents, knowingly or unknowingly, showed remarkable insight into the basics of professionalism.

#### **6.2.1.2 *Learning versus work***

Learning and working constitute a social process which strongly emphasises group work. Group work results in non-formal learning, which is emphasised wherever people gather and work together (Andresen [Sa]). This statement bears evidence to successful learning in the clinical field as most of the learning that results from learning and work is non-formal. According to Andresen ([Sa]), the principle legacies of experientialism are found in collaborative group work, and the wide range of "real world" experiences, including: workshops, clinical laboratory work and clinical placements.

Gaining new skills forms part of the concept *learning* in the clinical field. It seems that some student nurses experience learning only when they gain new skills. Student nurses considered repeating activities, which had already been mastered not to involve learning. As one of the participants said:

When I say that I am learning in the ward, is when I gain a new skill, but when I repeat what I have learned already, that is not learning, is working (Data:762).

Data display 6.1.1.2 contains evidence on learning new skills as part of the concept *learning*, and not *working*, within the clinical field.

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**DATA DISPLAY 6.1.1.2**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 1: THE CONCEPT “LEARNING” IN THE CLINICAL FIELD**  
**SUB-CATEGORY 2 : LEARNING VERSUS WORKING**

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- ◇ But if they (clinical facilitators) say because students are there they will do it they will bath the patients during the day because other nurses cannot do it because of shortage, even us, as students we can not do it, we feel not motivated (Data:535).
  - ◇ Learning always takes place when a student does something in the ward, we try to tell them, but we don't really know what we should do, I just go there being empty, it's better if we can go with the clinical tutor (Data:708).
  - ◇ It--- because at the end of the year when you do an OSCI, they expect us to do the right thing not what it should be done in the ward. So they say: (Pinch voice) “there is no time for doing that there is no staff”. It's like they use us students to patch up their staff members, so is not easy to learn like that (Data:756).
  - ◇ When I say that I am learning in the ward, is when I gain a new skill, (Data:762).
  - ◇ ... when I repeat what I have learned already, that is not learning, is working (Data:762).
  - ◇ I can learn from working only if what I am doing is new, but if I am repeating what I am doing everyday, like bed bath daily, that is not learning (Data:764).
- 

One implication of these statements could be that students perceive their status in the clinical field as being *supernumerary* (section 6.5.2.5) or as being observers.

Learning and work also emerged from the study conducted by Streubert (1994) in which student nurses were viewed as an ‘extern’, as they were expected to work, and to learn by doing things (Streubert 1994:31). However, a balance between working and learning should be struck to enable students to learn. On the other hand, student nurses need to acknowledge the occurrence of learning by doing, which does not differ that much from working as such.

In nursing the collective nature of ward routine, as opposed to the individual treatment of patients, has been seen as a possible barrier to student nurses’ learning (Hislop, Inglis, Cope, Soddart & McIntosh 1996:173). Birchenall (1999:173) gives the opinion that work based learning is intended to capture the essence of workplace activity as a principal source of learning. Based on the findings of the current research and the literature support, all stakeholders in the clinical field need to be orientated as to the reasons for student nurses’ allocation to the clinical field in order to have a common understanding of the expectations and benefits of clinical learning experiences discussed in sections 6.2.2 and 6.2.3.

## 6.2.2 Benefits of clinical field as learning experiences

Data display 6.1.2 gives an overview of the benefits gained from clinical experiences as perceived by student nurses. These benefits include the reinforcement of knowledge, enhancing understanding, an area of “prime” learning, correlating theory to practice and correlating practice to theory.

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<b>DATA DISPLAY 6.1.2</b>	
<b>THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING</b>	
<b>CATEGORY 2: BENEFITS OF CLINICAL FIELD AS LEARNING EXPERIENCES</b>	
<b>OVERVIEW</b>	
◇	Reinforcement of knowledge (Data display 6.1.2.1)
◇	An area of “prime” learning (Data display 6.1.2.2)
◇	Correlation of theory to practice (Data display 6.1.2.3)
◇	Correlation of practice to theory (Data display 6.1.2.4)

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### 6.2.2.1 Reinforcement of knowledge

This category on the reinforcement of knowledge in the clinical field is closely related to theory to practice integration and practice to theory integration. The difference is however that in reinforcement knowledge is merely acknowledged in the clinical area by students. The “oneness” of integration may still be absent.

According to the *Readers Digest Oxford Dictionary* (1993:1292) to *reinforce* means to *strengthen, support* or to *fortify*. Therefore, reinforcement of knowledge within the clinical fields refers to strengthening and confirming theoretical knowledge acquired from college classroom sessions of instruction. This knowledge is reinforced through both performing procedures and getting to know patients. It became clear from the participants’ explanations that this knowledge helped student nurses during continuous (formative) evaluations.

Student nurses specified that, what they have learned from patients helped them not to forget patients’ conditions. One student nurse, who illustrates this specifically, said:

... one thing I know is that I can not forget what I pick up from a psychiatric patient, they like wearing this bright colour, so I can not forget, or I see that schizophrenic patient they don’t take care of themselves of which is the characteristics which can help me to remember (Data:600).

Data display 6.1.2.1 exhibits statements on reinforcement of knowledge as experienced by student nurses as a benefit of clinical placements.

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<b>DATA DISPLAY 6.1.2.1</b>	
<b>THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING</b>	
<b>CATEGORY 2: BENEFITS OF CLINICAL FIELD AS LEARNING EXPERIENCES</b>	
<b>SUB-CATEGORY 1: REINFORCEMENT OF KNOWLEDGE</b>	
◇	I say this because in the classroom we learn more theory, teachers give us theory and we learn without proper understanding of whether it will work with real patients (Data:458).
◇	But when I was in the wards I then started understanding how theory and practical were related (Data:459).
◇	... it is interesting to be in the wards being with different patients with different diagnosis this is where I felt that I am learning more than being in the classroom (Data:461).
◇	From the positive patients, I learn from their participation because they usually share their problems with me, and as they are sharing I learn by understanding what is wrong with them (Data:591).
◇	I knew deep down in my heart that if I can get this topic during OSCE examination or test or final examination, I would never miss because I had the information at my fingertips (Data:117).
◇	Like one thing I know is that I can not forget what I pick up from a psychiatric patient, they like wearing this bright colour, so I can not forget, or I see that schizophrenic patient they don't take care of themselves of which is the characteristics which can help me to remember (Data:600).
◇	I followed step-by-step procedure, doing what was demonstrated and what I read about to enable me to learn and not to forget (Data:255).

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From the content of data display 6.1.2.1, it seems as if the clinical field strengthens knowledge gained from the classroom. This was recognised by previous researchers. According to Windsor (1989:151), student nurses clearly recognised the practice of nursing skills such as assessment and therapeutic communication in the clinical field. As Fothergill Bourbonnais and Higuchi (1995:39) put it, if one regards the clinical field as being imbued with knowledge, then through the selection of clinical learning experiences, student nurses can be encouraged to explore questions about what it means to nurse and to be *nurses*. Kosowski (1995:239) states that during learning how to care for patients, participants recalled many incidents when they summoned their imaginations and envisioned themselves or certain patients and their family members in the patients' circumstances. Successful use of creative imagination by participants in this study, facilitated an intuitive knowing of patients' feelings and needs. Through this creative process, participants gained insight into the patients' circumstances, needs, and desires (Kosowski 1995:239).

Student nurses also benefit from expert practitioners in the clinical setting (McGregor 1997:15). After experiences gained, student nurses felt more confident, better prepared, and more competitive. Reinforcement of knowledge also results from a mental rehearsal in clinical learning settings. Bowles (1995 in Grealish 2000: 232) points out that when practice is internally rehearsed, using imagination, psychomotor skills improved. When correct performance is frequently and directly reinforced, student nurses are likely to develop more rapidly (Neill et al 1998:19).

Reinforcement of knowledge as a benefit for clinical learning experience also finds reference in the work of Chan (2002:69) who believes that during clinical placements, student nurses are expected to develop competencies in the application of knowledge, skills, attitudes and values inherent to the nursing profession. Linking reinforcement of knowledge and clinical experience with clinical supervision Cole (2002:24) says it provides nurses with an opportunity to expand their thinking about patient care, and therefore their decision-making showed, improve their ability to engage (interact) with patients as explained in section 6.2.5.5.

### **6.2.2.2 An area of “prime” learning**

The concept “prime” refers to the *most important, leading, chief or key area* (*Readers’ Digest Oxford Dictionary* 1993:1207). Student nurses experienced the clinical field as such a key area for learning. Within the clinical field, student nurses could learn through interacting with various stakeholders available. These stakeholders are clinical facilitators, clinical staff, and patients with various diagnoses as well as peers. This becomes evident when one student nurse shared her experience:

I was free, because if I was in the ward I was learning **much** in the ward and from staff and patients (Data:403).

Participants consider the clinical field an area for prime learning mostly because they gained experiences relating to problem-solving.

Data display 6.1.2.2 exhibits statements regarding the clinical field as an area of “prime” learning.

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**DATA DISPLAY 6.1.2.2**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 2: BENEFITS OF CLINICAL FIELD AS LEARNING EXPERIENCES**  
**SUB-CATEGORY 3: AN AREA OF “PRIME” LEARNING**

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- ◇ I was free, because if I was in the ward I was learning **much** in the ward and from staff and patients (Data:403)
  - ◇ ... it is interesting to be in the wards being with different patients with different diagnosis this is where I felt that I am learning **more** than being in the classroom (Data:461).
  - ◇ When I am with a group of other students, I learn that when I am faced with a problem, how **best** can I find a solution, and if a patient is having a problem, how I can get the patient out of this problem (Data:573).
  - ◇ What I have experienced is that when I do nursing care, I was receiving back what I gave my patients through learning then I think patients are also a source of my knowledge (Data:604).
- 

In keeping with the contents of data display 6.1.2.2, An Bord Altranais (2003:2) strongly supports the clinical field as an area of prime learning by stating that clinical practice experience, whether in the hospital or in the community care setting, forms the central focus of the profession and is an integral component of the educational programme. To substantiate the notion of the clinical area being a key area of learning, An Bord Altranais (2003:2) delineates the essence of the clinical learning area as being a/an

- opportunity and privilege of direct access to patients/clients
- opportunity to experience the world of nursing and midwifery and to reflect on and to speak to others about what one experiences
- reference system for the student nurses to critically evaluate practice, to predict future actions and through reflection, reveal the thinking that underpins nursing actions
- motivations essential to acquire the skills critical to the delivery of quality patient/client care
- environment enabling student nurses to understand the integrated nature of practice and to identify their learning needs

The clinical field as an area of “prime” learning is also substantiated by other authors, including Laschinger (1992:112), Dunn and Burnett (1995:1166) and Massarweh (1999:44) as indicated in section 3.3.4.1 of this thesis.

In order to strengthen and ensure that the clinical field remains a “prime area” for learning as experienced by student nurses who participated in the current study, the state of highest perfection should be maintained through provision and utilisation for

both material and human resources. Important sources and resources are explained in section 6.2.6 of the current study.

### **6.2.2.3 Correlation of theory to practice**

Throughout the interviews, student nurses indicated the main benefit of clinical experiences as correlating theory and practice. It was mentioned that when student nurses were in the clinical field, they were able to articulate what they were taught in the classroom. Student nurses seemed to rely heavily on text books to assist them to align their worlds of *learning* and *work*. For instance:

During my block, I have learned that to make myself understand and not to forget a procedure, I need to practise it as it is in the book mixing with what I was taught in the classroom (Data:256).

Data display 6.1.2.4 exhibits further statements on correlating theory and practice as a benefit of clinical experiences.

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<b>DATA DISPLAY 6.1.2.3</b>
<b>THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING</b>
<b>CATEGORY 2: BENEFITS OF CLINICAL FIELD AS LEARNING EXPERIENCES</b>
<b>SUB-CATEGORY 3: CORRELATION OF THEORY TO PRACTICE</b>
◇ I have experienced that I am not learning what I was taught at the Campus, because when I go to the clinical field I was expecting to learn exactly what I was taught at the Campus (Data:28).
◇ As I dismantled the apparatus I had my book, which directed me that this is the apparatus (Data:74).
◇ Privately I told myself to check what the book says about all this, so that I can be sure I am doing the right thing (Data:81).
◇ I had to work hard, I have to read and align what is in the book and practical (Data:207).
◇ As a student, when I am being called for a demonstration and I had learned something, I feel happy and ready to apply it into practice (Data:252).
◇ When I go back to the patient, I then practice what I have learned from the class situation and do it to the patient... (Data:253).
◇ It is during my release period where I was allocated in hospital X where I actually understood what nursing is, by experiencing nursing by doing it in real patients (Data:457).

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In recent years, much research has been conducted which indicates aspects related to correlation of theory to practice. Students are placed in a clinical field where they can be assigned to a patient, develop a plan of care applying what they have learned in their theory courses, and then provide total patient care based on that care plan (Tanner 2002:51). Massarweh (1999:44) also purports that the clinical field provides an

opportunity to apply theory to practice and fosters problem-solving skills. Streubert (1994:29) indicates that student nurses commented that the theory they had learned in class had primary relevance in accomplishing specific skills in clinical practice. Similarly, Hislop *et al* (1996:175) found that student nurses experienced growth in their understanding of nursing by integrating theory and practice, and some student nurses were clearly absorbing the theory of their college course and deepening its meaning in subsequent practice (Hislop *et al* 1996:177). According to Bezuidenhout (2003:19), the integration of theory and practice is essential for ensuring successful learning outcomes. In the same vein, Du Plessis (2004:72) indicates that students experienced the integration of theory and practice as positive because they obtained insight in the physical, psychological and social needs of the patient, as they rendered basic nursing care.

As student nurses benefit in terms of making use of theoretical knowledge in the clinical field, clinical staff are expected to capitalise on the correlation of such theory to practice to advance student nurses' clinical learning. Emphasis in the clinical field should be on how to apply knowledge to care for the patients.

#### **6.2.2.4 Correlate of practice to theory**

Although it is generally accepted that clinical learning experiences are designed to promote the correlation of theory to practice, as discussed in section 6.2.2.3, student nurses in this study also gave clear indications that correlating *practice to theory* is another benefit of clinical allocations. In the same manner, the participants' experiences include that when they correlate practice to theory, they are able to

- remember classroom teaching better
- remember through picturing a specific patient during examination
- learn about conditions before receiving theoretical background

One student pointed out that:

...when I see a condition that is also interesting ... it's also important that I should go read about, do research on it so that I know what is happening so that I can understand it better (Data:613).

Data contained in data display 6.1.2.4 exhibit statements from interviews that reflect correlation of practice to theory as a benefit to clinical learning experience.

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**DATA DISPLAY 6.1.2.4**

**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**

**CATEGORY 2: BENEFITS OF CLINICAL FIELD AS LEARNING EXPERIENCES**

**SUB-CATEGORY 4: CORRELATION OF PRACTICE TO THEORY**

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- ◇ ... even when I went back to the campus, when they taught me something, I was thinking about practising it while listening to the class teachers (Data:150).
- ◇ Practising procedures by myself, helped me to remember during examination through picturing a specific patient, what he is suffering from, what he told me and what I told the patient and what I did to the patient (Data:262).
- ◇ Also taking what I learned in the ward and think about it when I am in the class (Data:362).
- ◇ There are many things, which I've learned in the ward before I've got the theory of it (Data:363).
- ◇ while learning about basic skills like bed bath, bed making, position changing, I happen to learn about caring of patients with specific conditions, signs and symptoms right in the ward before I learned the theory about these conditions in the class (Data:364).
- ◇ ... when I see a condition that is also interesting it's also important that I should go read about, do research on it so that I know what is happening so that I can understand it better (Data:613).

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The findings of this study coincide with several other researchers as pointed out in the literature reviewed in section 3.3.4. Some student nurses indicated that though the theory might illuminate the practice it was really the reverse process in their case, for example, the practice helped them to grasp theory (Hislop et al 1996:176). According to Hallet (1997:106), mastery of “basics” of nursing is a prerequisite for understanding. Dickerson *et al* (2000:191) add that it is easier to think about a real or ‘genuine’ experience than to imagine it; and student nurses gain insight into the needs of patients as they render care before learning about it from textbooks (Du Plessis 2004:72).

### **6.2.3 Student nurses’ expectations**

This category reflects on expectations of student nurses within the theme of a descriptive overview of the clinical field. Student nurses have expectations that guide both their perceptions and behaviour in the clinical field. According to Louw and Edwards (1998:578), expectations play an important role in how people respond to situations. From the data gathered student nurses’ expectations relate to themselves as student nurses, clinical facilitators, and clinical tutors. Data display 6.1.3 gives an overview of the sub-categories within the broader category “student nurses’ expectations”.

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**DATA DISPLAY 6.1.3**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 3.: STUDENT NURSES' EXPECTATIONS**  
**OVERVIEW**

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- ◇ Self expectations (Data display: 6.1.3.1)
  - ◇ Expectations and opinions of clinical facilitators (Data display: 6.1.3.2)
  - ◇ Student nurses' perceptions of clinical facilitators' expectations (Data display: 6.1.3.3)
  - ◇ Student expectations from nurse educators (Data display: 6.1.3.4)
  - ◇ Being with a clinical tutor (Data display: 6.1.3.5)
  - ◇ Expected conduct of clinical facilitators (Data display: 6.1.3.6)
- 

### **6.2.3.1 Self-expectations**

It is interesting to note that student nurses expect something from themselves while in the clinical field. According to Hamachek (1995:362), self expectations do not only relate to a belief in personal adequacy, but also communicate the message that students have the ability to do what is required of them. In a sense it communicates commitment.

Participants during the present study expected themselves to provide care and to learn from patients. In order to operationalise such expectations, they ensured that they have their own work plans. As one student nurse said:

When I go to work, I do have my own work plan "gore" (that) I'm going to do one, two and three (Data:483).

Data displayed 6.1.3.1 further portrays the expectations of student nurses in relation to learning in the clinical field.

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**DATA DISPLAY 6.1.3.1**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 3.: STUDENT NURSES' EXPECTATIONS**  
**SUB-CATEGORY 1: SELF-EXPECTATIONS**

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- ◇ ... my expectation was to continue taking care of patients from the ward where the night nurses were (Data:11).
  - ◇ When I go to work, I do have my own work plan "gore" (that) I'm going to do one, two and three (Data:483).
  - ◇ ... I practice to be the future nurse, who is an exemplar to the nurses and other student nurses (Data:521).
- 

These findings, agree with the findings of Baillie (1993:1045) who found that student nurses preferred being able to participate; viewing this as better learning. Similarly, it was found by Dickerson *et al* (2000:192) that student nurses were insightful about their

perspectives and recognised their need for change. Hence, if a student nurse expects change within him/herself, the expected change becomes reality, which is the aim of clinical learning. Student nurses are thus expected to have an internal locus of control because they take an active role in managing their every day's life within the clinical field. Student nurses with an internal locus of control believe that their performance is due largely to their own efforts and abilities, while those with external locus of control are more likely to believe that factors outside of themselves are responsible for their performance (Hamachek 1995:294). Yeaworth, Pullen, Zimmermann and Hays (2001:169) assert that new skills must be acquired to develop and maintain different expectations.

### **6.2.3.2 *Expectations and opinions of clinical facilitators***

Although student nurses expect themselves to participate in their own learning within the clinical fields, much has been revealed about what they expect from clinical facilitators. Data display 6.1.3.2 reflects both positive and negative aspects of student nurses' expectations from clinical facilitators. Such aspects include that clinical facilitators were expected to:

- offer advice
- assist in linking theory to clinical work
- assign and supervise student nurses
- guide and display good behaviour

One student summarised this by saying:

I expect the sister to help me learn, correct me if I do mistakes, showing me how nursing care is done related to patient's condition, show me procedures, actions that will help me nurse the patient (Data:503).

Over and above these expectations, student nurses also expect clinical facilitators to have knowledge of what is expected of students in the clinical field. Data display 6.1.3.2 exhibits evidence on the sub-category "expectations from clinical facilitators".

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**DATA DISPLAY 6.1.3.2**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 3: STUDENT NURSES' EXPECTATIONS**  
**SUB-CATEGORY 2: EXPECTATIONS AND OPINIONS OF CLINICAL**  
**FACILITATORS**

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**Positive aspects (6.1.3.2.1)**

- ◇ I expect the sisters to advise me if I make mistakes, to check what I am doing, to know what I am doing and I also expect them to assess me and evaluate my work (Data:212).
- ◇ When I become allocated in the wards, I expect the sisters to help me in linking theory to clinical work (Data:213).
- ◇ In the clinical field, I expect to be assigned (by the clinical facilitator) to a patient, develop a plan of care and learn how to apply what I have learned in the class in all the courses to the patient care (Data:361).
- ◇ I expect the sister to help me learn, correct me if I do mistakes, showing me how nursing care is done related to patient's condition, show me procedures, actions that will help me nurse the patient (Data:503).
- ◇ My expectation is that, sisters must know what is expected of student, what learning experiences we should cover at the end of our allocation in the ward (Data:774).
- ◇ They should also check if we have covered such learning (Data:775).
- ◇ I expect them to advice me and show me the learning that is related to my scope (Data:776)

**Negative aspects (6.1.3.2.2)**

- ◇ My personal opinion is that the sisters do not understand why student nurses are allocated in the wards or the hospital, because if they do, they would be interested in seeing student nurses doing procedures properly without doing short cut (Data:754).
- 

Similar findings surfaced in the study conducted by Dickerson et al (2000) in America. In this study, student nurses did not expect special treatment, but they expected some understanding from tutors that there are different ways of learning (Dickerson 2000 *et al*: 192). In support of student nurses' expectation to be advised, to be assisted in learning and to be guided by the clinical facilitators, the Code of Ethics for Registered Nurses (as cited in CNA 2004:9) expects nurses (as clinical facilitators) to provide mentorship and guidance towards the professional development of student nurses and other nurses.

Neither a mentor nor a clinical facilitator who is unwilling to teach can advise or guide student nurses in the clinical field. It is, however, also essential that clinical facilitators should understand their own expectations in relation to learning in the clinical field in addition to those of student nurses, in order to promote successful learning in the clinical field to the greatest possible benefit of student nurses.

### **6.2.3.3 Student nurses' perceptions of clinical facilitators' expectations**

Participants perceived clinical facilitators as also having expectations of them as student nurses. Student nurses believe that they are expected to observe abilities of clinical facilitators, develop skills on the application of knowledge as well as being able to do the right thing in the clinical field. However, there appears to be opinions of incongruence in these perceived expectations. As one student nurse indicated:

... at the end of the year when you do an OSCI, they (clinical facilitators) expect us to do the right thing not what is done in the ward ... (Data:756).

Data display 6.1.3.3 presents the perceptions student nurses have of clinical facilitators' expectations of students.

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<b>DATA DISPLAY 6.1.3.3</b>	
<b>THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING</b>	
<b>CATEGORY 3: STUDENT NURSES' EXPECTATIONS</b>	
<b>SUB-CATEGORY 3: STUDENT NURSES' PERCEPTIONS OF CLINICAL FACILITATORS' EXPECTATIONS</b>	
◇	This made me to feel worried as I was expected (by clinical facilitators) to combine information and observe abilities from different sisters during my stay in the ward. I was also expected to develop skills and apply knowledge, attitudes and values important in the nursing profession (Data:553)
◇	They expect us to do procedures the way they do it without us having the experience (Data 131).
◇	... because at the end of the year when you do an OSCI, they (clinical facilitators) expect us to do the right thing not what is done in the ward... (Data:756).
◇	The sisters in the wards expect us to behave professionally (Data:725)

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A significant aspect emerging from the data contained in the data display 6.1.3.3 is that student nurses perceive clinical facilitators to be expecting them to perform better. Windsor (1989:152) found that student nurses wanted their instructors to 'challenge them' by expecting 'a lot' and 'asking good questions.' They also wanted to know what instructors expected of them. If instructors within the clinical field expect more from student nurses, student nurses might show their initiative and consequently work harder and gain the expected knowledge and skills. This is supported by Girot (1993:118) who points out that third year student nurses are expected to apply knowledge to practise, show initiative and consider a holistic approach to their care. In the same vein, Wilson (1994:84) found that during interviews, student nurses alluded to some standards of perfection that instructors expected and against which they would be evaluated.

The findings of the present study are supported by many researchers. Student nurses often believed that faculty expected them to conform to educational standards and that faculty were not flexible about these expectations (Dickerson et al 2000:192). In addition to this, Chan (2002:69) believes that during clinical placements, student nurses are expected to develop competencies in the application of knowledge, skills, attitudes and values inherent in the nursing profession, while Carlson et al (2003: 36) point out that when student nurses go to the clinical field, everyone expects them to know already what to do. This is also echoed by the student who said:

They expect us to do procedures the way they do it without us having the experience (Data 131).

In line with the student nurses' perception that clinical facilitators expect them to apply knowledge, to do the right thing, overseeing that the right thing is indeed being done by student nurses during practica becomes the core of learning in the clinical field. In light hereof, it is alarming that clinical and practical examination outcomes could be articulated on theoretical knowledge that is incompatible with clinical know how, and that students could perceive clinical staff as having unrealistic expectations of them.

#### **6.2.3.4 *Expectations of nurse educators***

According to Sackney [Sa]), high expectations refer to a climate where the staff expect all students to do well, believe in their abilities to influence student achievement, and are held accountable for student learning.

Student nurses within the clinical field regard nurse educators from campus as important others in their clinical learning. Nurse educators are expected to visit the clinical field and to assess whether student nurses are on the right track. As one participant indicated:

The tutor should come so that she can check if we are doing the right thing through asking us questions when she finds us doing procedures, in so doing we will learn a lot (Data:619).

Data display 6.1.3.4 presents statements that indicate students' expectations of nurse educators.

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<b>DATA DISPLAY 6.1.3.4</b> <b>THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING</b> <b>CATEGORY 3: STUDENT NURSES' EXPECTATIONS</b> <b>SUB-CATEGORY 4: EXPECTATIONS OF NURSE EDUCATORS</b>
<ul style="list-style-type: none"><li>◇ The tutor should come so that she can check if we are doing the right thing through asking us questions when she finds us doing procedures, in so doing we will learn a lot (Data:619).</li><li>◇ But if . . . and sometimes when the tutor comes, she will expect me to do some procedure, and I'm like get used to doing those things, those procedures, but if ever they don't come, is not easy to learn (Data:733)</li></ul>

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Student nurses' expectations of nurse educators from the nursing campus is supported by Streubert (1994:30) who points out that (male) student nurses were most verbal about their expectations that faculty members have a responsibility to provide them with specific opportunities. Dickerson et al (2000:192) in this regard point out that student nurses expected a nurturing relationship with faculty members.

McCauley and McCausland (2001:496) agree with these expectations by mentioning that the actual accountability for learning and evaluation of student nurses' performance rests with the faculty members who collaborate with the preceptors in the education and evaluation of student nurses. Other related expectations include that faculty may help student nurses to recognise and develop their own unique potential by facilitating their own growth process through asking questions that enable students to contribute to discussions and elaborating on students' responses and questions (Vandever 2005:260).

Based on the complexity of the clinical field, nurse educators are also expected to use creative strategies which include giving student nurses multiple assignments as well as participating in nursing rounds (Stokes & Kost 2005:326). Nurse educators could participate during nursing rounds only if they visit the clinical field. As participants expect nurse educators from the campus to visit the clinical field, Sackney [Sa] outlines specific behaviours that elicit high expectations. These include: (1) being assertive; (2) being an excellent role model; (3) having a well articulated mission; (4) planning and decision-making through collaborative processes; and (5) regularly receiving and discussing performance appraisals.

### 6.2.3.5 *Being with a clinical tutor*

Student nurses seem to have a higher expectation of being with the clinical tutor than with clinical staff in general. Student nurses repeatedly expressed the importance of the clinical tutor's presence in the clinical area to:

- Motivate student nurses
- Determine their abilities and learning outcomes
- Evaluate their progress
- Guide against lingering
- Act as a person in charge of student nurses

Data display 6.1.3.5 exhibits statements on student nurses' expectations of being *with* the clinical tutor within the clinical field.

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<b>DATA DISPLAY: 6.1.3.5</b>	
<b>THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING</b>	
<b>CATEGORY 3: STUDENT NURSES' EXPECTATIONS</b>	
<b>SUB-CATEGORY 5: BEING WITH A CLINICAL TUTOR</b>	
◇	I expect the clinical tutor to welcome me, to know that I am in the ward, to know that now I am off duty, or sick, because she is the one who should teach me, correct me if I make mistakes (Data:242).
◇	I have also noticed that when the clinical tutor is in the ward we discuss with her what we feel we need to understand, she also determines our abilities and our learning outcomes, remind us if there is something interesting in the ward so that we can learn (Data:618).
◇	The clinical tutor should come so that she can check if we are doing the right thing through asking us questions when she finds us doing procedures, in so doing we will learn a lot (Data:619).
◇	Learning always takes place when a student does something in the ward, we try to tell them, but we don't really know what we should do, I just go there being empty, it's better if we can go with the clinical tutor (Data:708).
◇	I prefer to find a clinical tutor with knowledge, so that this person can guide me how to care for the patients. If I find the clinical tutor in the hospital, I think this person will show me how to do the right thing. When I do the procedures, or when I do patients' recordings, the clinical tutor will check if I am doing it right. This person will also help me by asking me questions (Data:714).
◇	I have also learned that it is better if clinical tutors are available at the beginning of our clinical exposure, to guide us properly, after we have progressed, then they can leave us to be on our own (Data:730).
◇	If we go to the ward there must be a person who is really in charge of the students, "gore" (that) every day, at the end of everyday, we have something, like I say hey- today I've learned one and two, because most of the time we don't really learn much (Data:778).

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Hart and Rotem (1994:30) found that being allocated a supervisor who was familiar with the clinical setting was seen as being advantageous by student nurses. Such a supervisor was better able to identify learning opportunities and resolve conflicts

between student nurses and staff. At the same time, a supervisor who was not a member of the teaching staff and who was unfamiliar with the curriculum could be a disadvantage in terms of the student nurse as the supervisor's objectives might be unrealistic. Nahas et al (1999:646) also indicate that as student nurses described a clinical field as an environment of uncertainty, they expected their clinical teachers to be accessible all the time as well as to be supportive and sensitive to their needs. These expectations of clinical tutors by student nurses might be indicative of not having mentors during their placements in the clinical fields. Special concern was raised by Edmond (2001:252) that for the majority of clinical fields the availability of mentors and preceptors cannot be guaranteed because of heavy workloads.

The findings of the current study reverberate in accordance to other recent studies. In the study conducted by Gray and Smith (2000:1546) student nurses had strong feelings that without a mentor, their learning experience would suffer, as they acted as gate keepers of learning. Similarly, Tanner (2002:52) suggests that a clinical expert spends a few hours with a small group of student nurses guiding them through the assessment of patients, and pointing out features salient for patient care planning.

From the findings of the present study, it is important to note that either a clinical tutor who is assigned permanently to supervise student nurses or a nurse educator from the campus, is expected to be with student nurses in order to prevent what student nurses so often experience; not being involved and "lingering".

#### **6.2.3.6 *Expected conduct of clinical facilitators***

From data display 6.1.3.6, it is clear that student nurses expect specific ways of conduct from clinical facilitators and clinical staff. Such conduct includes supervision of student nurses, guidance, showing good behaviour, positive attitudes towards student nurses, aiming at training better student nurses.

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**DATA DISPLAY: 6.1.3.6**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 3: STUDENT NURSES' EXPECTATIONS**  
**SUB-CATEGORY 6: EXPECTED CONDUCT OF CLINICAL FACILITATORS**

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- ◇ ... showing good behaviour, this is what I expect from the sisters myself as a student (Data:526).
  - ◇ And maybe most of the sisters should just improve on their attitude towards students they should also realise that they went through the same stage (Data:635).
  - ◇ They should actually aim to train better student that their final results can be the best of the students that they can possibly have (Data:636).
- 

With regard to the content of data display 6.1.3.6, Mellish et al (1998:138) mentioned that student nurses expect clinical facilitators to be role models on whom students could base their image of professional practice, actions, and attitudes and actually shape their professional practice. Additionally, Mellish et al (1998:139) assert that an imperfect role model (as explained in section 6.5.3.1), had to be helped to recognise and remedy her imperfections as far as possible. Impeccable conduct of role models is displayed through providing legal and ethical parameters, as well as remaining calm and dignified under pressure (Klopper 2000:41). Thus, as these student nurses expect spending time alongside clinical facilitators with exhibiting impeccable conduct in the clinical field, clinical facilitators should give mindful attention to caring in the clinical field (Nehls et al 1997:223). Mentors should thus show an interest in student nurses and be positive towards their courses (Baillie 1993:1050). The type of role model student nurses select include nurses who communicated effectively with patients, physicians, colleagues and student nurses and who demonstrated intelligence, clear thinking and client expertise (Attridge 1996:408).

#### **6.2.4 Teaching strategies emerging from the clinical field**

Regarding teaching strategies, participants experienced various elements relating to this in the clinical field. From the data follow-up discussions, coaching, peer support systems, clinical assignments, invitational learning, clinical supervision, questioning, as well as assessment, were identified. Data display 6.1.4 gives an overview of the sub-categories that make up this section on teaching strategies.

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**DATA DISPLAY 6.1.4**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 4: TEACHING STRATEGIES EMERGING FROM THE CLINICAL FIELD**  
**OVERVIEW**

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- ◇ Coaching (Data display: 6.1.4.1)
  - ◇ Peer support system (Data display: 6.1.4.2)
  - ◇ Clinical assignment (Data display: 6.1.4.3)
  - ◇ Invitational learning (Data display: 6.1.4.4)
  - ◇ Clinical supervision (Data display: 6.1.4.5)
  - ◇ Questioning (Data display: 6.1.4.6)
  - ◇ Modelling (Data display: 6.1.4.7)
  - ◇ Follow-up discussion (Data display: 6.1.4.8)
- 

### **6.2.4.1 Coaching**

Coaching is defined by Morton-Cooper and Palmer (1993:47) as an interactive, interpersonal process that involves the acquisition of appropriate skills, actions, and abilities that form the basis of professional practice. Grealish (2000:231) elaborates on this definition by stating that the coach is in a one-to-one relationship with the student nurse.

In the context of the present study, this one-to-one coaching relationship resulted from the interaction between the student nurse and either a clinical facilitator - more so, an enrolled nurse than a professional nurse.

Within the clinical field clinical facilitators and enrolled nurses acted as coaches who assisted student nurses with their personal progress and provided them with a safe environment for learning. Besides having clinical facilitators and enrolled nurses coaching student nurses, participants recommended that tutors from the campus should also avail themselves in the clinical environment to act as coaches. According to statements exhibited in data display 6.1.4.1, student nurses experienced coaching when they were being shown how to perform procedures, checked if what they did had been correctly done, advised and guided regarding how to perform procedures correctly, accompanied and being asked questions to evaluate their understanding. For instance, one student nurse said:

The main point is to know that whatever I have gathered is correct, with somebody who has experience to guide me lead me and tell me actually that I am in the right direction on whatever that I have obtained thus far (Data:625).

Data display 6.1.4.1 exhibits additional evidence for this sub-category.

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**DATA DISPLAY 6.1.4.1**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 4: TEACHING STRATEGIES EMERGING FROM THE CLINICAL FIELD**  
**SUB-CATEGORY: COACHING**

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- ◇ The enrolled nurse also showed me the apparatus and their functions (Data:76).
  - ◇ There was one sister in maternity ward every time she was accompanying me to check that everything she demonstrated I know (Data:312).
  - ◇ Other sisters use to call me and teach me how to order supplies ... (Data:480).
  - ◇ When the tutor visits the ward I feel that I learn a lot because she will guide me, coach me to do the right thing (Data:617).
  - ◇ Like giving me a task, saying maybe giving me an injection and that sister goes with me, showing me how and calculations and administration and I get a chance to learn or if ever I ask, may be she can explain. I find that it's like we are working together (Data:678).
  - ◇ If I find the clinical tutor in the hospital, I think this person will show me how to do the right thing. When I do the procedures, or when I do patients' recordings, the clinical tutor will check if I am doing it right. This person will also help me by asking me questions (Data:714).
- 

The evidence generally indicates student nurses' appreciation of coaching. The importance of coaching during learning in the clinical field is also emphasised by Grealish (2000:233) through asserting that without the support of a coach, student nurses would continue to adhere to familiar views of the world and accept the clinical world as it presents itself without healthy scepticism or the ability to be creative. Morton-Cooper and Palmer (1993:47) also stressed coaching as an important strategy within the clinical field. To coach effectively, the clinical facilitator must be flexible and enable collaborative goal setting (Grealish 2000:232).

#### **6.2.4.2 Peer support system**

Participants in this study found themselves being supported by their peers in terms of emotional support and in practising skills. This involves forming small groups to perform procedures and to learn from one another, as well as sharing experiences with one another, even off duty in the nurses' home. For example:

When I am with a group of other students, I learn that when I am faced with a problem, how best can I find a solution, and if a patient is having a problem, how I can get the patient out of this problem (Data:573).

Data display 6.1.4.2 shows supportive statements indicating that a peer support system is a teaching and support strategy emerging from the clinical field.

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**DATA DISPLAY 6.1.4.2**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 4: TEACHING STRATEGIES EMERGING FROM THE CLINICAL FIELD**  
**SUB-CATEGORY 2: PEER SUPPORT SYSTEMS**

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**General indicators/ Emotional support (6.1.4.2.1)**

- ◇ ... I didn't answer, but my colleague answered that we were studying since morning as we have realized that we are not involved during procedures (Data:190).
- ◇ In the nurses' home I then related what happened to my other colleague, then I told her how I feel about not going to that ward any longer (Data:197).
- ◇ My friend told me that I should not worry about the labels and attitudes being attached to us as students in the wards (Data:204).
- ◇ Me and my friend have just talk to each other about the sister's behaviour that lets just leave this sister and follow another one (Data:326).

**Peer teaching/Teaching milieu (6.1.4.2.2)**

- ◇ Since we are grouped in a small groups, if I insert a catheter now, the next time is their turn, and well in that way we do things as a group, but at the same time I also get a chance to do something myself (Data:569).
  - ◇ ... in a group we do things ourselves, we self evaluate ourselves, testing how much we understand as a group, and then we also form small group discussion to discuss what ever that we've learn during that day (Data:570).
  - ◇ When I am with a group of other students, I learn that when I am faced with a problem, how best can I find a solution, and if a patient is having a problem, how I can get the patient out of this problem (Data:573).
  - ◇ Receiving support to me means that it is important to be always mixing and sharing all the challenges with my colleagues (Data:577).
- 

Hamachek (1995:117) indicates that some of the functions of peers, as a support system, include being a useful stabiliser during a period of rapid transition; serving as a source of self esteem; providing an opportunity to practise by doing; and also acting as an important source of feedback. In the same vein, student nurses felt that they were able to meet the needs of patients due to peer group guidance and supervision (Du Plessis 2004:75). These aspects are presented in the evidence contained in data display 6.1.4.2. The importance of peer group support is, however, not always being appreciated. Carlson et al (2003: 35) found that student nurses were not allowed to assist each other in practising skills when the wards were quiet because they were expected to fulfil other roles. Anchored in the findings of the present study, it becomes evident that a peer support system of student nurses not only enhanced their commitment to engage themselves, but also prepared them to share their experiences with their peers, so that they can learn from each other's experiences. This is an important educational feat as well as a vital professional achievement.

Peer teaching, as indicated by participants, are akin to, though not the same as, what Killen (2000:100) refers to as, *co-operative learning* (see section 6.4.3). Some aspects

of cooperative learning could be applicable to participants' experience of peer teaching. These include:

- Positive inter-dependence
- Individual accountability (Killen 2000:100)

Positive inter-dependence in peer teaching and cooperative learning implies an important feature of professional practice, namely cooperation and possible teamwork. However, the individual's personal responsibility is not dissolved by the group and any "wrong learning" cannot be blamed on a peer. For this reason, the clinical environment as learning environment should continuously be scrutinised for the quality of information and learning that go around.

Peer and cooperative teaching and learning, and peer support systems are succinctly married as Johnson (1992 cited in Jacobs, Vakalisa and Gawe 2004:209) indicates: "Without co-operation, among individuals, no group ... would be able to exist".

#### **6.2.4.3 Clinical assignment**

According to White and Ewan (1991:92), "clinical assignment" refers to the assignment of student nurses in the clinical field to provide care to patients or groups of patients. Stokes and Kost (2005:334) view clinical assignments as an integral part of nursing practicum experiences.

Data display 6.2.4.3 contains evidence on clinical assignments.

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<b>DATA DISPLAY 6.1.4.3</b>
<b>THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING</b>
<b>CATEGORY 4:TEACHING STRATEGIES EMERGING FROM THE CLINICAL FIELD</b>
<b>SUB-CATEGORY 4:CLINICAL ASSIGNMENT</b>
◇ I remember... the sister in charge giving us assignment to come and present the following day (Data:63).
◇ ... like as they give me a patient to do a case study and to present it to the people working in the ward (Data:525).
◇ I like to look at the patients' files and see what they have done to the patient and then to tell the sister in charge this and this and that and to my peers.

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According to Wilson (1994:83), in order to accept the responsibility of patient care assignments, student nurses had to move out of the role of student nurses and into the

role as a nurse as discussed in supernumerary status of student nurses in section 6.5.2.5. Fothergill Bourbonnais and Higuchi (1995:40) further advise that the clinical assignment should be based on specific clinical objectives and reflect the student nurse's abilities as well as the level of training. Stokes and Kost (2005: 336) also mention that clinical assignments should also be based on student nurses' needs, skills level, complexity of the clinical environment, and patients' severity of illness.

In the study conducted by Fothergill-Bourbonnais and Higuchi (1995:40-41) regarding the selection of clinical learning experiences, clinical assignments were found to be imperative in assisting student nurses to gain learning experiences. According to Fothergill-Bourbonnais and Higuchi (1995), more competent student nurses who benefit from being challenged, should be given more complex assignments. Stokes and Kost (2005:334) outline the benefits of clinical assignments as providing student nurses with the opportunities to:

- Select experiences that are based on personal learning needs
- Experience a degree of control over education
- Interact with practising professionals (clinical staff) during the process of selecting experiences

#### **6.2.4.4 *Invitational learning***

To "invite" means to request, call, summon, encourage, attract, and ask (*Corel WP Thesaurus* 1995). Invitational learning includes learning, which results from a request between two people in the clinical field namely the student, and the clinical facilitator. According to Klopper (2000:104), by being invitational, the learning accompanist creates an atmosphere, which contributes to the adult learner's self-concept. This becomes evident when one participant says:

I remember her saying: "if there are some concern during my stay in this ward, where you think that we should improve or help you learn please ask us in this ward" (Data:313).

Data display 6.2.4.4 reflects statements from interviews on invitational learning as a teaching strategy within the clinical field.

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**DATA DISPLAY 6.1.4.4**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 4: TEACHING STRATEGIES EMERGING FROM THE CLINICAL FIELD**  
**SUB-CATEGORY 4: INVITATIONAL LEARNING**

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- ◇ As a student, when I am being called for a demonstration and I had learned something, I feel happy and ready to apply it into practice (Data:252).
  - ◇ I remember her saying: "if there are some concern during my stay in this ward, where you think that we should improve or help you learn please ask us in this ward" (Data:313).
  - ◇ She even told me that I should also see myself as part of the whole staff and make learning possible, and I should be a teachable student (Data:314).
  - ◇ other sisters use to call me and teach me how to order supplies... (Data:480).
  - ◇ Well it depends upon the institution, other institutions; the clinical tutor will welcome me neh- and show me around the hospital (Data:710).
- 

No reference was found in the literature about invitational learning in the clinical field by itself, but information on invitational learning was found in general education under the inviting tutor, and teacher immediacy (Russel, Prukey & Siedel 1982; Kearney, Plax, & Wendt-Wasco 1985).

Russel et al (1982:35-38) explicated the inviting strategies that can be classified as *personally* inviting and *professionally* inviting. These authors established that personally inviting behaviours, include maintaining eye contact, listening carefully and remembering a student's interests. According to these authors, these behaviours meet the lower needs for security, belonging and love on Maslow's Hierarchy of Needs (Russel et al 1982:53-36).

*Professionally* inviting behaviours are consistent to those actions by the tutor which focus on increasing the student's efficiency, competence and self-esteem. These accordingly contribute to learning itself. Logically, these meet Maslow's higher levels of needs such as self-esteem, knowledge, and self-actualisation. The artfully inviting teacher (facilitator) is one who utilises personal and professional invitations, integrating these behaviours in such a skilful manner that it is often difficult to distinguish among them (Russel et al 1982:36). The outcome of these invitations is the lived experience of student nurses in the clinical field, toward which the art of nursing is directed.

Another notion from literature in general education which resembles that of the inviting tutor, is what Kearney et al (1985:61-74) call teacher *immediacy*. Kearney et al (1985) identified the following non-verbal behaviours as indicative of teacher immediacy: positive head nods, smiles, eye contact, vocal expressiveness, overall body

movements, purposeful gestures, and direct, relaxed and open body position, and close physical distance.

#### **6.2.4.5 Clinical supervision**

Clinical supervision was most frequently referred to, as a teaching strategy emerging from the data. According to Lyth (2000:723), clinical supervision is seen as the controlling mechanism instituted to directly oversee the skills utilised in the treatment of patients. McSherry, Kell and Pearse (2002:30) explicitly point out the aim of clinical supervision as promoting high clinical standards and developing professional expertise by supporting staff, and helping to prevent problems in a busy, stressful practice setting. Cole (2002:22) adds to this definition by mentioning that clinical supervision is a system of *action learning* that combines high support and high challenge with the ultimate aim of improving patient care.

From the present study it appears that clinical supervision is being carried out by enrolled nurses, clinical facilitators and clinical tutors. According to statements in data display 6.1.4.5 clinical supervision is conducted to:

- Engage student nurses in the responsibilities relating to patient care
- Emphasise the correct approach in performing activities in the clinical field
- Ensure that student nurses spend quality time within the clinical field
- Evaluate students' knowledge in terms of the procedures demonstrated to them

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**DATA DISPLAY 6.1.4.5**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 4: TEACHING STRATEGIES EMERGING FROM THE CLINICAL FIELD**  
**SUB-CATEGORY 5: CLINICAL SUPERVISION**

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- ◇ There was one sister in maternity ward every time she was accompanying me to check that everything she has demonstrated I know it (Data:312).
  - ◇ These supervision skills also include guidance showing good behaviour, this is what I expect from the sisters myself as a student (Data:526)
  - ◇ I have learned that the whole supervision from the clinical tutor is important to me as a student nurse (Data:730 ).
- 

In line with the findings displayed in data display 6.1.4.5, Cole (2002:24) outlines three main functions in relation to clinical supervision namely

- Formative function, which includes development knowledge and skills
- Restorative function, involving support and 'recharge'
- Normative function, which relates to the maintenance of professional standards as well as assisting people (student nurses) to value what they do

One participant summarised these functions of clinical supervision in the following way:

The main point is to know that what ever that I have gathered is correct, with somebody who has experience to guide me lead me and tell me actually that I am in the right direction on whatever that I have obtained thus far (Data:625).

In the study conducted by Bezuidenhout (2003:20) with regard to guidelines for clinical supervision, participants clearly linked clinical supervision with guidance. In the articulation, they defined guidance as continuous assessment and evaluation to ensure that the highest standards of nursing care are adhered to. Guidance also finds reference in peer support systems as indicated in section 6.2.4.2.

#### **6.2.4.6 Questioning and answering**

According to Rowles and Brigham (2005:304), questioning is an expression of inquiry that invites or calls for a reply, an interrogative sentence, phrase, or gesture. Rowles and Brigham (2005) further outline the advantages of questioning and answering as: increasing interaction; promoting discussion from multiple points of view; allowing student nurses to discuss concepts from their own experiences; stimulating students to ask higher level questions; promoting higher levels of problem-solving skills; and transferring learning from classroom to clinical field.

Data display 6.1.4.6 displays evidence that questioning as teaching strategy also emerges from the clinical field. The evidence in this display is sub-categorised into:

- General indicators
- Questions and good communication
- Asking questions
- Being questioned
- Questioning as invitational element

In order to clarify issues in the clinical field, student nurses generally ask questions. Asking questions in a sense indicates introspection on the part of the person (student nurse) who asks the question. Student nurses experienced the environment that permitted interaction via questioning, conducive to learning as indicated by the following statement:

... followed the one (sister) who was giving injections, and that one was good, she was willing uri (that) we must learn, because when we went to her she said uri (that) "if you have problems, ask; I am here with you" (Data:329).

In instances where student nurses were encouraged to ask questions, this acted as invitational learning as discussed in section 6.2.4.4. All clinical staff are, however, not always available and open to students posing questions about the clinical field. Some health workers appear too busy to attend to students' questions. As one participant said:

Most of the time we are with sisters, health workers like doctors I can ask questions - but some are like too busy, I can see that this person just want to do his/her work and go (Data:664).

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#### DATA DISPLAY 6.1.4.6

### THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING

#### CATEGORY 4: TEACHING STRATEGIES EMERGING FROM THE CLINICAL FIELD

##### SUB-CATEGORY : QUESTIONING AND ANSWERING

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##### **General indicator (6.1.4.6.1)**

- ◇ As I was busy asking the questions, the enrolled nurse also showed me the apparatus and their functions (Data:76).

##### **Questioning and good communication (6.1.4.6.2)**

- ◇ Good communication make me to develop in my clinical learning, and as a student, when a sister is a good communicator I feel safer, and being free to ask questions, even if I realise that I have made a mistake, I feel free to discuss my mistake with the sister (Data:166).

##### **Asking questions (6.1.4.6.3)**

- ◇ ... then I told myself that if there is something to gain when I ask questions so that I gain my knowledge I will ask (Data:316).

##### **Being questioned (6.1.4.6.4)**

- ◇ But when they (clinical facilitators) ask questions it help us to learn to understand, as if we give wrong answers they correct us (Data:690).
- ◇ The tutor should come so that she can check if we are doing the right thing through asking us questions when she finds us doing procedures, in so doing we will learn a lot (Data:619).

##### **Questioning as invitational learning (6.1.4.6.5)**

- ◇ I remember in the surgical ward, the sister in charge telling me that I can ask any question (Data:266).
- ◇ We followed the one who was giving injections, and that one was good, she was willing uri (that) we must learn, because when we went to her she said uri (that) "if you have problems, ask; I am here with you" (Data:329).
- ◇ Most of the time we are with sisters, health workers like Doctors I can ask questions- (Data:664).

##### **Negative aspects in asking questions (6.1.4.6.6)**

- ◇ ... they say I must ask questions, sometimes is not easy to ask questions (Data:647).
  - ◇ They do ask questions and then a---but when I argue with them, when I ask questions they won't answer me. When I ask they say me, I know too much, how could I ask that (Data:690)
-

Although it was found that, student nurses who participated in Hart and Rotem's (1994:30) study commented that, a questioning approach by student nurses was not always welcomed; many studies purport questioning as being important to enhance clinical learning. Correspondingly, participants in a study conducted by Hallet (1997:107) mentioned the importance of answering student nurses' questions and questioning them, often with open-ended questions, which would encourage reflection. According to Little (2000:394), student nurses experienced a new sense of authority when allowed to ask questions about fundamental aspects of their role. Chabeli and Muller (2004:63) advise that student nurses should be *encouraged* to ask thought provoking questions. This could be achieved through creating a safe space for student nurses to be able to ask questions that clearly indicate a transparent relationship between clinical facilitators and student nurses.

#### **6.2.4.7 Modelling**

Reilly and Oermann (1992:330) state that *modelling* is a method of learning whereby the student nurse seeks to imitate a behavioural pattern of another individual who exemplifies an ideal behaviour to the student nurse. According to participants' experiences within the clinical field, as shown in data display 6.1.4.7, student nurses enjoyed learning through imitating desired behaviour from clinical facilitators. These behaviours came to light when clinical facilitators:

- Performed their work precisely with the sense of respect to patients as well as student nurses
- Displayed good behaviour and being an exemplar nurse
- Avoided performing procedures wrongly
- Demonstrated support to both patients and student nurses

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**DATA DISPLAY: 6.1.4.7**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 4: TEACHING STRATEGIES EMERGING FROM THE CLINICAL FIELD**  
**SUB-CATEGORY 7: MODELLING**

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- ◇ I have learned that I **enjoy** to work with sisters and staff who do their work correctly, of course with a sense of respect. The respect should also include respecting us as students (Data:36).
  - ◇ For example, I learn emotional support of patients, counselling patients, recording, administrative aspects, handling conflict, etcetera, all this kind of information is learned in the ward, they also teach us good behaviour like being an **exemplar** as a sister (Data:260).
  - ◇ Sometimes when I see people doing things wrongly, and I imitate like I did, and I did realise that going for teatime or lunch hour for longer period is wrong doing, I have actually learned from such behaviour that I need not do that **when I am a sister** (Data:524).
  - ◇ Giving support to me means talking to the person, listening to the person while talking, showing understanding to his problems; and this can be done by a sister with student or a patient, us students always **imitate** in the ward (Data:579).
- 

The findings of the present study on modelling are supported by other studies. According to Hart and Rotem (1994:32), for many student nurses the experience of working side by side with a sympathetic and skilled registered nurse was a highlight of their clinical placement. Wilson (1994:83) in this regard, points out behaviours, which form the attributes of a model to aspire towards, namely:

- confidence, thoroughness, neatness, respect, and supporting
- ethical behaviour, such as not talking about other instructors or students' inappropriate
- protecting the patient, and supporting the student nurses

Streubert (1994:31) mentions that student nurses' acquisition of skills and knowledge of a particular role should lead him/her to wanting to be like individuals functioning in the aspired position. The most powerful and frequently reported incidents of role modelling caring, occurred when student nurses observed and imitated clinical facilitators such as staff nurses and clinical instructors effectively integrating philosophical, psychosocial, and technical caring activities while caring for neurologically impaired patients. However, for these participants, caring role models also embodied a 'caring way of being'. This way of being was described as a blend of genuine warmth and respect integrated with caring 'behaviors and mannerisms' (Kosowski 1995:238). Jordanian student nurses indicated that their learning could be better facilitated by clinical teachers whose personality conveys confidence and respect for student nurses (Nahas et al

1999:646). Gray and Smith (2000:1546) also substantiate this by stating that a good mentor is a role model who is professionally, organised, caring and self confident.

Erickson-Owens and Kennedy (2001:139), advise that qualities that keep the learner engaged include an enthusiastic facilitator who also models desired behaviour congruent to the nursing profession. Du Plessis (2004:76) points out that most respondents respected the fact that the tutors were role models who not only had the psychomotor skills needed for nursing, but also demonstrated thorough knowledge, values and norms. According to An Bord Altranais (2003:2), each nurse has a continuing responsibility to junior colleagues and he/she is obliged to transmit acquired skills and attitudes in both by word and by example.

#### **6.2.4.8 Discussions**

This category on discussions relates to all teaching strategies that emerged from the clinical field discussed up to this point. Face to face discussion provides opportunities for clinical facilitators to probe students' understanding more deeply in order to gain more precise feedback about student nurses' learning progress (White & Ewan 1991:83). During the present study, student nurses expressed their quest for follow-up discussions with clinical facilitators in all clinical fields. As one of them said:

Follow up session; discussion can be conducted with sisters and our peers. Discussion of outcomes will help us to know whether we did meet our objectives, otherwise there is no point of being given objectives without them being discussed after each rotation (Data:634).

Data display 6.1.4.8 exhibits further evidence relating to follow-up discussion as a teaching strategy emerging from the clinical field.

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**DATA DISPLAY 6.1.4.8**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 4: TEACHING STRATEGIES EMERGING FROM THE CLINICAL FIELD**  
**SUB-CATEGORY 8: DISCUSSIONS**

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- ◇ We (student nurses) need to have a follow up session on whatever we have picked up at the hospital setting so that we can discuss those objectives with them (Data:622).
  - ◇ Follow up session; discussion can be conducted with sisters and our peers. Discussion of these outcomes will help us to know whether we did meet our objectives, otherwise there is no point of being given objectives without them being discussed after each rotation (Data:634).
  - ◇ They (clinical facilitators) prepare, and come and discuss with us, then if they give us this lectures, we talk about it, and it was like a discussion (Data:688).
-

The analysis of the findings from the current study demonstrates the importance of follow-up discussions as a teaching strategy in the clinical field. According to Van der Wal (2002:117), student nurses need to discuss the things they become aware of, think about their feelings, about the situation as such and about their own thoughts and fears. Through individual discussions and dialogues with the student nurses early in their clinical placements, what the student nurses can achieve could be indicated, making student nurses feel that the clinical facilitators are interested in their progress (Grealish 2000:232).

In accordance with the findings of the current study, Chau, Chang, Lee, Ip, Lee and Wooton (2001:113) stress that discussion is an approach in the clinical field to enhance critical thinking. Jooste (2003:96) adds that in order to motivate student nurses, the supervisor should be able to present positive and clear discussions on a wide array of topics.

Follow-up discussions of a wide array of topics within the clinical field can be done including discussions based on set outcomes students have to attain. These could act as a vehicle to reflect on student nurses' achievements in terms of clinical learning. The extent, to which student nurses are engaged in the follow-up discussions, depends upon the willingness and preparedness of both student nurses and significant others, to involve themselves in such discussions and their abilities to reflect on lessons learnt from their clinical experiences.

### **6.2.5 What is learned**

What is learned is a focal point in *Theme 1: Descriptive overview of the clinical field*. Data display 6.1.5 gives an overview of the sub-categories making up the category. The nine sub-categories reflect Edmond's (2001) statement that learning to interact with, and to manage the clinical context in all its complexity, is a major task in nursing practice (Edmond 2001:253).

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**DATA DISPLAY 6.1.5**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 5: WHAT IS LEARNED**  
**OVERVIEW**

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- ◇ The dynamics of the clinical field (Data display 6.1.5.1)
  - ◇ Arts and science autonomy (Data display 6.1.5.2)
  - ◇ Nursing ethics (Data display 6.1.5.3)
  - ◇ Caring (Data display 6.1.5.4)
  - ◇ Interacting and connecting (Data display 6.1.5.5)
  - ◇ Composite skill (Data display 6.1.5.6)
  - ◇ Taking own decision (Data display 6.1.5.7)
  - ◇ Perseverance and “imperviousness” (Data display 6.1.5.8)
  - ◇ Self-knowledge (Data display 6.1.5.9)
- 

### **6.2.5.1 *The dynamics of the clinical field***

According to the *Corel WP Thesaurus* (1995), the word “dynamics” refers to: “those forces that produce change in any field or system” and “the branch of any science concerned with forces”. Forces in this instance also refer to “under currents,” or “interrelationships”. In educational terms it implies aspects of the “hidden” curriculum.

The dynamics of the clinical field as experienced and learned by student nurses include:

- Continuity
- Becoming a team member
- Interpersonal relations
- Uncertainty and ambiguity of the clinical environment

Data display 6.1.5.1 shows evidence of the dynamics of the clinical field as part of what is learned by student nurses in the clinical field.

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**DATA DISPLAY 6.1.5.1**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 5: WHAT IS LEARNED**  
**SUB-CATEGORY 1: THE DYNAMICS OF THE CLINICAL FIELD**

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**Continuity (6.1.5.1.1)**

- ◇ The reason being that if a person who give us report gives it patient by patient it becomes easy for me as a student to pick up what is wrong with the patient (Data:19).

**Becoming a team member (6.1.5.1.2)**

- ◇ I have learned to act together with other team members as nurses (Data:13).
- ◇ As a member of the team, I am able to learn how to solve problems related to nursing care, I am able to learn to get used to the ward quickly and productively to changes in the ward, and work towards achieving my goal as a nurse (Data:183).
- ◇ Involving myself in the entire situation helps me learn what is going on with my patients in the ward (Data:566).
- ◇ In this project I've learned that I should take pride of my work take care of patients as if they are my relatives or my friends (Data:386).

**Interpersonal relations (6.1.5.1.3)**

- ◇ At times these nurses would help me to understand the behaviour of some sisters who had negative attitude to students (Data:495).
- ◇ When I talked to these sisters and they kept quiet, the assistant nurse will tell me not to worry about that as the sister is doing that to every one not me alone (Data:496).
- ◇ Basically, if I find sisters who were suppose to guide me and displaying right behaviour making themselves comfortable, I just tell myself as a student that why should I worry about this or that (Data:519).

**Ambiguity and uncertainty of the clinical field (6.1.5.1.4)**

- ◇ From negative patients I learn that even if they are negative, I should see them as human beings who need help from me as a nurse (Data:588)
  - ◇ ... it is so difficult ... something can be right and wrong for I have to learn this (Data:712)
- 

Perceived from the point of view of the existential baseline from which the present study departed, student nurses learned much more than mere curriculum contents (knowledge and skills). According to the report from the International Council of Nurses (ICN 2006:55), the production and transfer of knowledge through education represent dynamics that are part of the basic structure of the nursing workforce (including student nurses). This could only be done by developing an understanding of the dynamics, forces and undercurrents in the clinical context. According to Edmond (2001:254), the novice coming into a post must first be made aware of the components and activities involved in the role, then learn how to interact within the context and how to put the basics together before her internalisation process begins. These basics include the dynamics within the clinical field. Student nurses also learned to understand the contexts of clinical situations within which they exist every day.

The multi-dimensional context and dynamics of the clinical field hold a potential towards conflict. Muller (2002:227) asserts that the nursing unit (clinical field) is a stressful

environment with a potential for conflict resulting from the attitudes of personnel, individual responsibilities of personnel which are not explicitly clarified, differences in values especially in respect of the attributes of quality nursing care in the unit, communication patterns and, management and leadership styles (Muller 2002:185). Penn-Kekana, Blaauw, Tint, Monareng and Chege (2005) conducted a study on the documentation of nursing staff dynamics in maternal health services, to explore the factors associated with underlying dynamics. According to these researchers, these dynamics include human resource processes such as staff turnover, absenteeism, average length of stay in a facility, vacancy rates and workload (Penn-Kekana et al 2005:2). The results of Penn-Kekana et al's (2005:2) study, indicated that poor promotion opportunities, feeling unsupported by management and having bad relationships at work were all associated with lack of organisational commitment and consequently also with a potential for conflict. Learning the dynamics of the clinical field, could contribute towards student nurses' more successful adjusting to the work environment.

#### **6.2.5.2 Arts and science autonomy**

The clinical experiences of student nurses provided them with opportunities to acquire autonomy in the art and science of nursing – the freedom to make prudent and binding decisions consistent with the scope of one's practice (Moloney 1992:230). Chinn and Kramer (1999:7) refer to the art of nursing as nurses' actions take on an element of artistry, creating unique, meaningful, deeply moving interactions with others that touch common chords of human experience. According to Chinn and Kramer (1999:187), a large part of the difficulty in specifying the art of nursing resides in the fact that it is expressed in the “being-knowing” of the nurse – the nurse knowing the essence of self as a nurse. This relates to an existential phenomenological concept underlying the present research namely *embodiment* (see section 2.5.1). In this regard, and in phenomenological terms, participants focused on patients regarding the specific ‘meanings’ that events have for the individual patient. Embodiment was expressed by one participant as:

Practicing procedures by myself, helped me to remember during examination through picturing a specific patient, what he is suffering from, what he told me and what I told the patient and what I did to the patient (Data:262).

Data display 6.1.5.2 reflects evidence indicating experiences of gaining autonomy in the arts and science of nursing during learning.

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**DATA DISPLAY 6.1.5.2**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 5: WHAT IS LEARNED**  
**SUB-CATEGORY 2: ARTS AND SCIENCE AUTONOMY**

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- ◇ Learning the right way means practicing procedures according to the manner in which I was taught in the campus, or doing the procedure according to the way it is in the book so as not to hurt the patient (Data:144).
- ◇ As the patient tells me that, I knew in my mind that it was not because my hands are hurting or not, it was because I followed step by step procedure, doing what was demonstrated and what I read about to enable me to learn and not to forget (Data:255).
- ◇ Practicing procedures by myself, helped me to remember during examination through picturing a specific patient, what he is suffering from, what he told me and what I told the patient and what I did to the patient (Data:262).
- ◇ They also teach us good behaviour like being an exemplar as a sister and also practising procedures by ourselves (Data:260).
- ◇ During that period even if the sister was not there, I was able to do procedures alone (Data:409).
- ◇ The morning teachings help me to understand the conditions which are there in the ward, how to take care of patients, treatment and so on (Data:686).

In correlating the findings of the present study with existing literature, Mellish et al (1998 5) believe that the art and science of nursing is based on knowledge derived from the natural, biological and human sciences. Orem (2001:293) corroborates this by stating that the art of nursing is the intellectual quality of individual nurses (including student nurses) that allows them to make creative investigations, analyses and syntheses of the variables and conditioning factors within nursing situations in order to work towards the goal of the production of effective systems of assistance for clients. In their art, nurses envision, design, and assist others. This is the most important aspect of learning in the clinical field based on the fact that without *realising* the art of nursing, no *professional* learning results.

To further define artful nursing Van der Zalm and Bergum (2000: 215) as well as Carper (1978 cited in Chinn and Kramer 1999:6) refers to it as aesthetic knowing and knowledge. According to Johns (1995:228), aesthetic action involves grasping, interpreting and envisioning the clinical situation; responding with appropriate skilled action and subsequently reflecting on whether outcomes were effectively attained. Empirical knowing and knowledge thus seem to be the base for aesthetic knowing and knowledge. Empirical knowledge is, factual, descriptive and ultimately aimed at developing abstract and theoretical explanations (Carper 1978:15). Chinn and Kramer

(1995:7) elaborate on this definition through basing empirics on the assumption that what is known is accessible through the senses of seeing, touching and hearing.

### **6.2.5.3 *Nursing ethics, professionalism and etiquette***

Nursing ethics refers to standards of conduct or right behaviour based on moral judgement (Reilly & Oermann 1992:305). According to Werner (2003:29), ethics refers to the study of moral principles or values that determine whether the conduct or actions are right or wrong. Using this working definition of nursing ethics, Chinn and Kramer (1999:154) point out that morality and ethics interrelate in that ethical knowledge and knowing can provide a template for judging and evaluating moral standards and behaviour. According to Chinn and Kramer (1999:154), morality is often shown on a less deliberative and conscious level. Daily expressions of belief about the “right thing” (section 6.2.1.1), the “good”, and the “noble” are filtered through lenses that are in the clinical field, influenced by role models through displaying professionalism and etiquette as discussed in section 6.2.4.7. Naude et al (2000:121) substantiate this by mentioning that nursing ethics is concerned with the nurse’s behavioural codes and safe practice.

According to the American Association of Colleges of Nursing (AACN 1998), professional values such as integrity, altruism, autonomy, respect for human dignity, and social justice are learned and reinforced in educational and practice settings (Kopala 2001:54). Participants experience and learn aspects of professionalism and etiquette in the clinical field through general things such as addressing their clients appropriately, wearing uniforms, and generally taking pride in their work. According to Moloney (1992:7) professionalism outlines a set of attributes that include commitment to one’s work and an orientation towards service rather than personal profit.

Data display 6.1.5.3 contains statements on nursing ethics as learned during clinical placements.

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### DATA DISPLAY 6.1.5.3

#### THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING

#### CATEGORY 5: WHAT IS LEARNED

#### SUB-CATEGORY 3: NURSING ETHICS, PROFESSIONALISM AND ETIQUETTE

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##### General indicators (6.1.5.3.1)

- ◇ When the patient did not want me to provide care and learn from him, I have learned that it is always important to **respect** patients all the time (Data:295).
- ◇ By putting a patient in a clean environment, creating an environment which is home like, seeing patients seated in the garden chairs with their relatives, makes me learn that the patient is just like any other normal person who also have needs to be comfortable, **needs** to be respected and being treated like a human being (Data:353).
- ◇ If I see a patient in need of something, I don't have to wait to be reminded I had to **do it right away** (Data:387).
- ◇ I saw patients being so free to share their problems with me as a student. What I have learned from that ward was that caring doesn't mean giving medication, but also being **concerned** about general things, like relating to patient and to other staff members like you do at home (Data:393).

##### Correcting aspects of personal ethos (6.1.5.3.2)

- ◇ I have learned that I should be **other focused** (Data:296).
- ◇ Showing respect **helped me** to be more **enthusiastic** about my cause and me, it taught me how to care about patients as people and also taught me consideration (Data:303).
- ◇ Through going to the nurses home (during working hours) and sleep, I have learned that, that kind of behaviour does not help me, because even though I was in the nurses home I was not free, because of **the thought** of going off before time (Data:490).
- ◇ Sometimes when I see people doing things wrongly, and I imitate like I did, and I did realise that going for teatime or lunch hour for longer period is wrong doing, I have actually learned from such behaviour that **I need not do that** when I am a sister (Data:524).

##### Professionalism and etiquette (6.1.5.3.3)

- ◇ I remember my tutors at the campus stating that I should not refer to my patients as that one or call patients with **diagnoses** (Data:24).
  - ◇ I've learned that patients should be treated as patient like **human beings**, and respect them as living people we treat them as we treat ourselves (Data:352).
  - ◇ In the model, we had to practice caring ethos for example, wearing **white uniforms** on the specific days (Data:370).
  - ◇ If I am in uniform, patients **respect me** as a person who cares (Data:377).
  - ◇ So when we bring back white uniform, I mean all white this is in a way bringing back the original nursing (Data:378).
  - ◇ By wearing white, I learn to be professional not wearing jeans at work. If I put on jeans I don't look like a professional somebody (Data:380).
  - ◇ In this project I've learned that I should take pride of my work (Data:386).
  - ◇ ... a psychology tutor in the nursing campus warning us that we should not call patients by their diagnoses or call them as objects as if they were not existing (Data:26).
  - ◇ I've learned how to behave properly in the wards, and be a good person (395).
  - ◇ I've learned how to deal with problems, respecting an **environment** and people around me (396).
  - ◇ From negative patients I learn that even if they are negative, I should see them as human beings who **need help** from me as a nurse (588).
  - ◇ Well, it helps me to realise that I shouldn't treat a psychiatric patient as a schizophrenic in W 9 I should treat such a patient as miss whoever. It helps me to learn so that in **future** I can become a better health care worker and not treats patients according to their symptoms but as a person (606).
  - ◇ And I feel that a patient who comes with emotional problem, need emotional support, love, caring, to feel special and improve on their condition (611).
  - ◇ It also helps me to know what I must do to the patient as a human being, how I must pay respect to this human being during giving of care (683).
-

Reading through the evidence contained in data display 6.1.5.3 a central theme that comes to mind is that of *appreciation*. This is quite understandably as doing what is “good” and “right” call for a certain amount of appreciation. Interestingly, this appreciation extends to self, other and the environment.

The evidence in data display 6.1.5.3 indicates that student nurses learn how to maintain reasonable standards of nursing ethics in the clinical field. Subsequently student nurses acquired moral knowledge and knowing. Chinn and Kramer (1995:8) refer to moral knowledge as making moment-to-moment judgements about what should be done, what is good and right, and what is responsible. Furthermore, Johns (1995:228) interprets moral knowledge as knowing what is right or wrong and being committed to taking actions on this basis. Van der Zalm and Bergum (2000:215) base moral knowledge on underlying principles such as:

- Truth telling
- Respecting the rights of people to make decisions for themselves
- Sensitivity to timing
- Listening, and attending to parameters of the situation

Similarly, CARNA (2006), directly supports the data contained in data display 6.1.5.3, through outlining the Code of Ethics for Registered Nurses which is structured around eight primary values that are central to ethical nursing practice:

- Safe, competent and ethical care
- Health and well-being
- Choice
- Dignity
- Confidentiality
- Justice
- Accountability
- Quality practice environments

Moloney (1992:7) supports some findings of the present study by stating that upon entering a profession, one becomes committed to the development of characteristic attitudes and responses, even to wearing acceptable attire such as the nurses’ uniforms

that distinguish nurses from other professional workers. Nurses' uniforms and attire indicate signs of professionalism which could be learned by student nurses. Similarly in the LP in an attempt to respond to clients' complaints, special projects were put in place to try to restore nursing ethos and professionalism as discussed in section 1.2.3.

Based on the findings of the present study, as well as the reviewed literature, it can be assumed that student nurses learn more about the profession during clinical field exposure than in the classroom. It is important that professionalism be role modelled at all times to enable them to absorb professional behaviour. Role modelling is explained in section 6.2.4.7.

#### **6.2.5.4 Caring**

This category on learning caring is closely related to the previous one on ethics, professionalism and etiquette. According to Van der Wal (2005:17), *caring* is not merely the present continuous form of the verb "to care" but it is a collective noun representing a whole array of humanistic tenets as well as ethical, moral and religious concepts and principles that have implications for all human conduct, actions and endeavours. Essentially, caring constitutes the quality of the subject-object relationship (intentionality) and is defined in terms of existing socio-religious and cultural norms and values. Caring is ultimately about doing what is right and good and is as such an ethic in itself. Structurally caring entails two major categories namely feelings (affective) and doing (psychomotor and interpersonal). In more colloquial terms, caring entails more endearing human attributes such as warmth, kindness, empathy and nurturing.

Statements purporting caring as gentleness are reflected in data display 6.1.5.4. Becoming aware of being "caring" was affirmed to one participant by a patient. As the participant recalled, a patient asking her:

... how long will I be working in that unit, because other nurses hands are painful but my hands are not painful (Data:254).

"Painful hands" signify roughness during the performance of procedures as experienced by the patient. Not having painful hands signifies "gentleness."

Student nurses also learned from relating to the patient as a human being, showing empathy and authenticity, which also portray caring towards clients in the clinical field. Data display 6.1.5.4 contains further evidence of learning aspects of caring in the clinical setting.

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**DATA DISPLAY 6.1.5.4**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 5: WHAT IS LEARNED**  
**SUB-CATEGORY 4: CARING**

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**Gentleness (6.1.5.4.1)**

- ◇ I remember one day while I was working in the dressing room, while removing bandage to the patient gently as it was demonstrated to me, applying the clinical field dressings while on the other hand communicating with the patient, then this patient asked me how long will I be working in that unit, because *other nurses hands are painful but my hands are not painful* (Data:254).

**Caring ethos project (6.1.5.4.2)**

- ◇ As students we were involved in the number of projects that were taking place during clinical field aiming at improving patient care (Data:341).
- ◇ Sometimes we become too busy to smile or to touch patients in the ward, I find myself with one very ill patients while other patients has no-one to talk to, this caring ethos project give means to fulfil such needs to our patients (384).
- ◇ In the caring ethos project we were not allowed to give patients food, or to bath patients without communicating and smiling with the patient (Data:382).

**Dedication (6.1.5.4.3)**

- ◇ I have learned that I should never give up in caring for my patients I must show dedication of excellence in everything I do, during bathing, feeding, giving medication and during assessment that I do to my patient, communication should be through out (Data:390).

**Relating (6.1.5.4.4)**

- ◇ What I have learned from that ward was that caring doesn't mean giving medication, but also being concerned about general things, like relating to patient and to other staff members like I do at home (Data:393).
- ◇ A better health worker is when I give real caring friendship by opening my heart to show who I am to my patient, it also include knowing these patients, their humankind and sharing how kind I am (Data:608).

**Empathy and authenticity (6.1.5.4.5)**

- ◇ Well actually they help because at times I tell myself that I don't wanna treat patients like that; I don't wanna be like that person. I think I learn a lot because if I was in that patient's shoes I don't wanna be treated the same (Data:610).
- 

The most important aspect of learning in the clinical field is to learn how to care and to be caring. With regard to the content of data display 6.1.5.4, Girot (1993:116) also found that there appears to be an association between the significance of the student's own self concept and caring. The lack of a caring concern for particular types of patients, as illustrated by student nurses in Girot's (1993) study, appears to disenable student nurses from caring. This was perceived as incompetence by participants.

According to Streubert (1994:30), it is only through providing holistic care that a student nurse could learn caring in the clinical field. This holistic care could be provided during interacting and connecting as described in section 6.2.5.5. According to Kosowski

(1995:237), caring is learned through recalling the details, and understanding of caring experienced during patient interactions. In Kosowski's (1995) study, participants recalled numerous details of patient care experiences in which they created, expressed, or experienced caring. Several manifestations of caring which emerged across interviews were summarised as connecting, sharing, being holistic, touching, advocating, being competent and feeling good (Kosowski 1995:238). The outcome of these interactions remained the learning of clinical skills. Beck (1997:413) also gives practical examples regarding how caring is learned in the clinical field. For instance, providing nursing care to dying patients taught student nurses something about themselves, caring unconditionally and non-judgementally, and they also learned that nurses do not only help people to get well, but they also nurse people who die. According to Neill et al (1998:19), being a novice student nurse necessitates pondering the personal impact of taking on the role of caring for the sick.

If student nurses provide holistic care to patients, through being gentle, displaying dedication, being empathetic as well as involving themselves in the caring ethos projects, learning to be caring could be viewed as a process that sustains the intrinsic value of the individual (both student and patient) and which posits caring as a reciprocal process of learning occurring between students and patients.

#### **6.2.5.5 *Interacting and connecting***

According to Orem (2001:102), interacting means reciprocal action or influence within the context of nursing practice situation, considering what each one (student nurse, patient and clinical staff) says and does and their influences upon one another. According to Orem (2001), if there is no *nurse*, there is no *relationship*, no *interaction*, no *nursing* and consequently no learning in the clinical field. Loving (1993) in Neill et al (1998:19) refers to connecting as a term which described a number of strategies that student nurses used to gain access to resources and knowledge necessary to learn clinical skills.

The evidence gathered during the present research also shows that student nurses learned to interact and connect with other team members and with patients within the clinical field. Data display 6.1.5.5 exhibits statements about student nurses' experiences of interacting and connecting as expressed during interviews.

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**DATA DISPLAY 6.1.5.5**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 5: WHAT IS LEARNED**  
**SUB-CATEGORY 5: INTERACTING AND CONNECTING**

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**With colleagues (6.1.5.5.1)**

- ◇ I have learned to act together with other team members as nurses (Data:13).
- ◇ Well, in that way we do things as a group, but at the same time I also get a chance to do something myself (Data:569).

**With patients (6.1.5.5.2)**

- ◇ I have also gained knowledge about reading the patient's file and relate it to what I see with my eyes in connection with the patient's illness, signs and symptoms and response to medications or care (Data:14)
- ◇ I've noted that if I do something on a patient, patients do something for me, because if I give care to them, they shared their needs with me, and that helped me learn a lot (307).
- ◇ In this project I've learned that I should take pride of my work take care of patients as if they are my relatives or my friends (Data:386).
- ◇ during assessment that I do to my patient, communication should be through out (Data:390).
- ◇ Touching greeting and smiling became a tradition (Data:391).
- ◇ ...I must do to the patient as a human being, how I must pay respect to this human being during giving of care (683).

**With clinical staff (6.1.5.5.3)**

- ◇ saying maybe giving me an injection and that sister goes with me, showing me how and calculations and administration and I get a chance to learn or if ever I ask, may be she can explain. I find that it's like we are working together (Data:678).
  - ◇ She even told me that I should also see myself as part of the whole staff and make learning possible, and I should be a teachable student (Data:314).
- 

Student nurses learn interacting and connecting with colleagues, patients and clinical staff while in turn these serve as sources and resources for learning as discussed in section 6.2.6. Windsor (1989:152) indicates that when interacting and connecting between student nurses and staff nurses increased, student nurses' "fear of staff nurses" decreased. Student nurses indicated that their relationship with instructors, staff nurses, peers and patients was important in their experience as it provided a pleasant atmosphere in which to work; a well accepted issue in promoting learning.

Neill et al (1998:19) also indicate that sophomore student nurses not only connected to obvious mentors (facilitators) but also to peers, patients, and families. Student nurses pointed out that being connected enhanced the ability to develop and learn. Neill et al (1998) also found that student nurses who were forceful in seeking or making connections, increased both the number and quality of learning opportunities for themselves.

The ability to connect is central to the art of nursing as described in section 6.2.5.2, and thus also to the nurse-patient relationship (Elcock 1997:140). The connected relationship occurs when the nurse (student nurse) sees the patient first as a person, and only then as a patient. According to Antrobus (1997:830), when nurses come to know clients during interactions, the reciprocal nature of coming to know and responding to each other, creates a caring synchrony, which unfolds creatively in a nurse-patient relationship. This ultimately results in learning from one another. Chinn and Kramer (1999:190) elaborate on this by stating that the synchronous arrangement of narrative and movement elicits a synchronous interaction, with a timing and flow among all elements, including those present in the situation. The observable synchronicity symbolises the deeper levels of connections between the nurse and the patient and is symbolic of the meaning within the connection. According to Vygotsky's theory of interaction, learning, our knowledge, ideas, attitudes and values are shaped mainly through our interaction with others, and this interaction occurs within a specific cultural context (Mellish et al 1998:32). In the case of clinical learning this usually entails a confluence of the patient's culture and the nursing (western medical) culture. From this socio-cultural perspective it is evident that others play a crucial role in development as "individuals construct meaning for themselves but within the context of interaction with others" (Kerka 1998:2). The interaction displays a dialogically cooperative character, based on mutual faith, which is directed at the acceptance of responsibility, interdependence and individual liability, and it encourages the adult learner towards self-direction (as discussed in section 6.2.5.7) and motivation (section 6.4). Connecting with clinical staff also assists student nurses overcoming their fears of making mistakes (Diekelman 2001:60); fear that could erode learning (6.3.3.6).

#### **6.2.5.6 Composite skill**

Schultz and Schultz (1998:386) distinguish between the two types of work overload. The first type is the *quantitative overload*, which is referred to as the condition of having too much to do within the available time, while the second type is the qualitative overload, involving work that is too difficult. According to Potgieter (2003:210), work overload is a contributory factor of stress. When a student nurse experiences stress, his/her learning is likely to be affected negatively. Student nurses learned how to manage the clinical workload in situations where, either a shortage of staff occurred or

where wards became very busy due to different circumstances. Data display 6.1.5.6 exhibits evidence regarding learning to manage the workload in the clinical field.

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**DATA DISPLAY 6.1.5.6**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 5: WHAT IS LEARNED**  
**SUB-CATEGORY 6: COMPOSITE SKILL**

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- ◇ I felt like I am being overworked as other students were delegated to do some other activities; but if I usually feel that I am overworked I only do what I can manage to do for a day (Data:41).
  - ◇ I have also learnt that even when the situation is busy I can do all the things that are necessary (Data:138).
  - ◇ Because being made to patch up staff shortage makes me to repeat skills that I have already mastered and when I do that, I am not learning anything new but to learn how to deal with a lot of work (Data:758).
- 

Edmond (2001:254) is of the opinion that managing multiple activities going on at the same time in the clinical area is a composite skill which, once it has been mastered, is invisible and usually referred to only in the most cryptic terms. From the findings of the current study, it is clear that student nurses do a lot of work, which assist them to learn how to coordinate and organise the clinical field; a composite skill. Chan (2002:70) points out that clinical experiences require difficult adjustments for student nurses as they move from an environment that encourages thinking to an environment that encourages doing; moving between theory (college) and practice (the clinical learning field). According to Fothergill-Bourbonnais and Higuchi (1995:41), student nurses should be able to make decisions with many interacting variables and constantly changing circumstances. All of these might further assist students in managing unpredictable changes in workload.

#### **6.2.5.7 Self-directedness**

According to Gravett (1991 as cited in Klopper 2000:44) self-direction implies to deliberately make decisions and choices based on a wide framework of knowledge and experiences with the aim of achieving goals and of regulating and critically reflecting on intellectual activities. White and Ewan (1991:109) expand on the definition by mentioning that self-directed learning may also engage student nurses in issues relevant to their personal growth, clinical skills and understanding of the theoretical base of their practice. The students' existing experience and skills also serve as a source

which they learn to employ in the clinical field. The ability to think laterally and to be more self-directed seems to be an attribute at this level (Girot 1993:118).

The evidence displayed in data display 6.1.5.7 indicates that student nurses learn to take decisions, to be assertive and to be in control of self in the clinical field. These feature in students' insistence on being involved in deciding on practice placements.

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**DATA DISPLAY 6.1.5.7**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 5: WHAT IS LEARNED**  
**SUB-CATEGORY 7: SELF-DIRECTEDNESS**

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- ◇ I have learned that sometimes it is important for me as students to be given an opportunity to choose where we prefer to go and do a practical (Data:232).
  - ◇ I have learned that to find solutions, I must choose the best one and do it, as a student (Data:443).
  - ◇ I have also learned I don't have to be a sheep I don't have to always do what other students are doing or telling me what to do (Data:445).
  - ◇ I also learned how to be strong and not to depend on other people and also how to be independent and stand up for my rights (Data:446).
  - ◇ If what other students and other people say is wrong and I am convinced that I am right, I have learned to stand up for myself and make the decision I feel It's right (Data:447).
- 

In the line of self-directedness of student nurses, Windsor (1989:153) found that the amount of supervision that the instructor (clinical facilitator) provided, was important to student nurses as they indicated that they wanted to develop independence from the facilitators as they progressed toward graduation and disliked being watched too closely when they felt they had adequately mastered skills. In corroboration, Hart and Rotem (1994:28) indicated that student nurses in the clinical field mentioned that it was important to show initiative, and accept appropriate levels of autonomy as discussed in section 3.3.2.1. If student nurses have self directed experiences they can also develop a sense of accountability and responsibility. Because of their self directedness, student nurses developed the ability to identify their own learning needs (Dana & Gwele 1998:63). The self-directed student nurse (and adult learner) displays self-direction, has experience, demonstrates a specific learning readiness and a learning orientation which is task orientated and problem directed, approaches learning intentionally, is an active constructor of own knowledge, and acquires meaning and understanding through reflection (Klopper 2000:14).

In the study conducted by Gray and Smith (2000:1547) student nurses pointed out that they should be guided towards independence from the very beginning of their practical placements, allowing them the opportunity to show initiative.

Potgieter (2003:98) outline the features of self-directedness which could be learned by student nurses in the clinical field as:

- sharing of common vision and goals in line with strategic objectives
- strong influence when setting goals and accepting responsibility for tasks
- accomplishment of tasks and solving problems without supervision
- have autonomy to make important decisions
- display high levels of trust among members

Student nurses should be encouraged and be supported to make their own decisions as they could be expected to do this for the rest of their professional lives. There is, however, also evidence that points towards a tendency in the clinical field for clinical facilitators to be very directive. In this regard also see the data overview for theme 2 as exhibited by data display 6.2 on negative experiences in the clinical area and the overview for theme 3 on erosive factors in clinical learning in data display 6.4.

#### **6.2.5.8 Perseverance and “imperviousness”**

Perseverance as persistence, determination, will power, self-control as well as strength of mind (*Corel WP Thesaurus* 1995), and even imperviousness, were also experienced and learned by student nurses in the clinical field. Data display 6.1.5.8 contains evidence of student nurses learning perseverance and “imperviousness” in the clinical field. Student nurses learn how to control themselves in situations where they:

- become angry
- become frustrated
- have to deal with difficult patients

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**DATA DISPLAY 6.1.5.8**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 5: WHAT IS LEARNED**  
**SUB-CATEGORY 8: PERSEVERANCE AND “IMPERVIOUSNESS”**

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- ◇ Whether angry or not I had to do my work (Data:283).
  - ◇ I should not act upon the patient’s anger or with reaction towards hospitalisation (Data:589).
  - ◇ I should help the patient to be able to recover and go home, I have learned that even if the patient is having these reactions I have to keep on doing my work (Data:590).
  - ◇ Even if the patient reacts I need to be there (Data:603).
- 

The ground for exercising perseverance and “imperviousness” stems mostly from the “difficult patient” as reflected by data display 6.1.5.8. In this regards, Deetlefs, Greeff, and Koen (2003:27) indicate that denial of disease by patients provokes the anger of nurses. It is thus encouraging to note that participants in the current study learned to persist and have resistance towards the reactions of patients, which could include anger towards students themselves. Essary and Symington (2005:49) further state that difficult patients can lead clinicians, including student nurses, to feel less enthusiastic about health care delivery and feeling manipulated (Essary & Symington 2005:49). This could be extremely detrimental to learning in general in the clinical field.

#### **6.2.5.9 Self-knowledge**

Self-knowledge is described by Carper (1978:18) as concrete, subjective and existential, and is concerned with the ‘knowing’ encountered in actualising self. Johns (1995:229) points out that self-knowledge is the sum of the knowledge a practitioner uses to practise. Stevenson and Haberman (1998:118) assert that people can only know themselves ‘as they appear’ to ‘themselves’ on introspection of the ‘inner sense’ and to others as *embodied* human beings acting in a shared world.

Johns (1995:229) relates to self-knowledge within the clinical field through outlining three related factors. These factors include:

- The perceptions of one’s feelings and prejudices within the situation
- The management of one’s feelings and prejudices in order to respond appropriately
- Managing anxiety and sustaining oneself

The findings of the present study are in keeping with the above-mentioned factors as student nurses pointed out that the following issues are acquired during clinical learning:

- self-knowledge in relation to remembering content
- self-knowledge concerning one's own weaknesses
- being considerate
- self-knowledge regarding what enhances one's own learning

Self-knowledge is reflected in data display by student nurses "telling themselves," "knowing themselves," and "realising things about self." All of these are related to positive self-talk. Data display 6.1.5.9 evidences statements relating to learning about self (self-knowledge) as part of "what is learned" in the clinical field.

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**DATA DISPLAY 6.1.5.9**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 5: WHAT IS LEARNED**  
**SUB-CATEGORY 10: SELF-KNOWLEDGE**

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- ◇ I have learned that to make myself understand and not to forget a procedure, I need to practice it as it is in the book mixing with what I was taught in the classroom (Data:256).
  - ◇ I knew I was short tempered, I was even aware of my weaknesses as a person which could even limit me to learn and become a professional nurse (Data:290).
  - ◇ By consideration, I mean I've learned to consider other people, not myself only (Data:305).
  - ◇ I've learned to put myself second (Data:306).
  - ◇ I've learned that if I put myself first all the time, I won't get somewhere because people won't help me achieve my goals (Data:308).
  - ◇ I've learned that if I involve myself as much as possible especially in doing critical procedures like bed bath, bedpan rounds, I will never get used to nursing (Data:442).
  - ◇ Even though I felt frustrated I used to learn and told myself that this will pass, and indeed I got used to the situation it passed (Data:424).
  - ◇ Getting used to the situation influenced my learning in the sense that I've adjusted myself and start enjoying being in the ward (Data:426).
- 

According to Elcock (1997:141), personal knowing is about knowledge of self and relates to the way nurses view others. Others could be patients as well as clinical facilitators in the clinical field. According to Antrobus (1997:830), nursing knowledge is constructed and contextualised within the activity of the nurse as "knower" and includes the integration of formal, tacit and personal knowledge. Responding authentically to self and others can act as a means of becoming aware of beliefs, emotions and personal meanings that are brought to the relationship with another individual (Van der Zalm & Bergum 2000:216).

Self-knowledge should be used by the student nurse as fundamental vantage point in knowing other people to be able to utilise them as sources of knowledge as explained in section 6.2.6 and in data display 6.1.6.

## 6.2.6 Sources and resources of knowledge and skills

It can be logically deduced that for learning to occur as indicated in section 6.2.5 (What is learned) there must be a source or resources from which such learning originates. In this regard, Daley (1997:104) defines knowledge as a social construction of information that occurs through a process of meaningful learning and perspective transformation. The “social” referred to by Daley also includes the clinical field as learning field. In this regard Mazabow, Burke and Stuart (2004:55) indicate that human action takes place in a reality of understanding, which is created through social construction and dialogue.

The participants indicated various sources and resources from which they could tap knowledge and skill (experiences) during their clinical placements. Data display 6.1.6 gives an overview of categories that emerged from the data in this regard.

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<b>DATA DISPLAY 6.1.6</b>	
<b>THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING</b>	
<b>CATEGORY 6: SOURCES AND RESOURCES OF KNOWLEDGE AND SKILL</b>	
<b>OVERVIEW</b>	
◇	Experienced staff (Data display 6.1.6.1)
◇	Reference materials (Data display 6.1.6.2)
◇	Patients as a source of learning (Data display 6.1.6.3)

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### 6.2.6.1 *Experienced staff*

Rolfe (1997:94) differentiates experienced staff in terms of an *expert* who has a combination of “knowing how” and “knowing that.” It is therefore the acquisition of know-how or personal, experiential knowledge that separates the novice or the inexperienced from the experienced *expert*. This distinction relates well to the professional developmental path within the clinical learning field laid out for the student nurse, from inexperienced novice to experienced expert.

It is shown in data display 6.1.6.1 that student nurses consider experienced members of staff as valuable sources of knowledge and skills. *Experienced staff* includes clinical

facilitators who possess experience and are willing to share their knowledge and skills with student nurses. Knowledge regarding basic nursing skills was also obtained from enrolled nurses as well as enrolled nursing auxiliaries who are always available within the clinical field. Doctors are also said to be helpful as knowledge sources.

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**DATA DISPLAY 6.1.6.1**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 6: SOURCES AND RESOURCES OF KNOWLEDGE AND SKILL**  
**SUB-CATEGORY 1: EXPERIENCED STAFF**

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- ◇ I consider **sisters** to be the right people in learning in the clinical field in the wards, the reason is that they have undergone the same training and it will be easy for them to pass these experiences to me as a student (Data:83).
- ◇ But also, **enrolled nurses** helped me in learning the basic skills like bed bath, feeding, taking of temperatures (Data:84).
- ◇ **Doctors** also play a role in teaching us especially during ward rounds (Data:85).
- ◇ For the information, which is not in the book, I usually learn from the **professional staff** with experience, sisters also portray to us and we learn ... (Data:259).
- ◇ ... in most cases when I come across a diagnose, I ask the sister or a doctor during rounds to explain to me ... (Data:264).
- ◇ Usually I felt I was learning a lot with those experienced staff who worked in the units for a long time like **enrolled** nurses and enrolled nursing **auxiliary**, during my first year, they use to teach me how to take blood pressure, temperature accurately (Data:492).
- ◇ Those permanent nurses they do more **practically**; I like working with them because they do more practically, they know patients and they know practical nursing better than sisters because they are more in administration work (Data:504).
- ◇ The main point is to know that whatever that I have gathered is correct, with somebody who has **experience** to guide me lead me and tell me actually that I am in the right direction on whatever that I have obtained thus far (Data:625).
- ◇ This also includes what we get from doctors, sisters and other staff members (Data:628).
- ◇ Sisters gave guidance in the clinics (Data:724).
- ◇ Students should be assisted by sisters to learn (Data:768).

Streubert (1994:31) states that individuals interact with others based on experience. The experience could either be with the clinical facilitator or an enrolled nurse. According to the AACN, (2002:5) mentoring of the new graduate by experienced professional nurses can be a key component in producing beneficial outcomes for both the mentor (clinical facilitator) and mentee (student nurse). The findings of the present study supports the study conducted by the Canadian Nurses Association (CNA 2003) regarding the value of nurses in the community. From the CNA's (2003) study, respondents mentioned that they get most organizational support from other nurses especially experienced nurses who provide counseling for more junior nurses (student nurses) about complex cases and community situations (CNA 2003:7). Nurses, including student nurses in the community, are generally managing their job responsibilities due to mentoring from their peers and experienced nurses (CNA 2003:9).

Experienced, competent nurses in the profession foster healthier work environments and promote the successful transition and growth of new or developing nurses (CNA 2004:3). In the context of the present research study, new or developing nurses could be student nurses in the clinical field. In another example at St. Joseph's Health Care in London as reported by CNA (2004:23), an experienced staff member who is called a clinical practice coach, works in a formal one-to-one relationship within the work setting, to advance the learner's (student nurses') quality of practice.

Experienced staff as a source of learning is also supported by the UK Department of Health's (1999 as cited by RCN 2005:5) report on *making a difference*, through stating that:

- every practitioner shares responsibility to support and teach the next generation of nurses/midwives
- it is important that, as with medical education, nurses and midwives are taught by those with practical and recent experience of nursing and midwifery

If experienced staff in the clinical field mentor student nurses, successful transition and growth in the profession could result.

#### **6.2.6.2 Reference materials**

Reference materials refer to an alternative source of information used by students in the clinical area when they experience difficulty in understanding information resulting from the clinical setting (Mellish et al 1998:201). According to statements exhibited in data display 6.1.6.2, students gained knowledge from the following reference materials:

- Text books
- Outcomes and objectives
- Guidelines for evaluations
- Workbooks

From these reference materials, it appears that student nurses take their prescribed books along to the clinical field (wards) for the purpose of locating additional

information. This supports the findings in sections 6.2.2.3/4 on correlating theory to practice and practice to theory. Outcomes and objectives were also used as sources of information as were guidelines for evaluations and workbooks.

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#### DATA DISPLAY 6.1.6.2

##### THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING CATEGORY 6: SOURCES AND RESOURCES OF KNOWLEDGE AND SKILL SUB-CATEGORY 2: REFERENCE MATERIAL

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###### **Text books (6.1.6.2.1)**

- ◇ I usually take the specific book that is related to conditions in that ward because I want to refer (Data:176).
- ◇ The book doesn't provide information for all situations, what I usually take my book with me, is for reference of information, which is in the book (Data:258).

###### **Outcome and objectives (6.1.6.2.2)**

- ◇ I have learned that in order to learn in the clinical field I have to focus on the specific outcomes, what I must achieve corresponding to my level (Data:138).
- ◇ Objectives help me learn as they guide me as to what I am suppose to learn in the ward though we get objectives, but sometimes they give us very late during the year, I find that I go to the wards not really knowing what to do, (Data:702).

###### **Guidelines for evaluation (6.1.6.2.3)**

- ◇ Guidelines helped us learn.... But when we go there we have tools like evaluation tools, where we are evaluated and also fill up the workbook (Data:737).
- ◇ The sisters use the guidelines and tools to help us learn what is in the ward, and as students we use these guidelines to refer (Data:739).
- ◇ If as a student I don't have the tool with me; I find the tool there, so that the sisters should evaluate me (Data:740).

###### **Workbooks (6.1.6.2.4)**

- ◇ If we students complete the workbook we search information in the clinics by ourselves, then we complete it, when we don't get this information we ask the sister, in doing that we are learning something. The tool also help in giving guidance of how I should do things, and when I don't understand they give guidance on completion of a workbook or a tool (Data:742).
- 

The contents of data display 6.1.6.2 are corroborated by Windsor's (1989:151) findings that students were devoted to studying through reading books, journals, and consulting others in the clinical field. According to Mellish et al (1998:123) workbooks are designed to ensure that certain aspects of work are covered and to guide learning activities whereby student nurses can learn through observations of activities which should be carried out in the ward while undertaking practical learning experiences. Williams (2001:135) relates workbooks with portfolios, which are collections of work that are used to document, monitor, and evaluate performance. Mellish et al (1998:123) advise that a workbook should not be seen as an end in itself, but as a means to an end, learning the practice of nursing, so as to be able to care for people with health-related needs.

Student nurses also experienced that in order to learn in the clinical field, they should focus on their objectives as reference materials in line with the level of their learning. By

focusing on achievable outcomes successful learning could result (Grealish 2000:232). By focusing on the outcomes set for students specifically relating to their level of advancement and the clinical fields in which they are working could assist in sifting and ordering the vast amount of information from both reference materials and intrinsic clinical resources.

### **6.2.6.3 *Patients as a source of learning***

In data display 6.1.6.3 statements on patients and patients' records and files as sources of learning are presented.

According to student nurses' experiences features relating to the patient as a source of learning which are important include:

- Maintaining good relationships with patients
- Knowing patients
- Patient attitudes
- Informed patients
- Reciprocation between students and patients

Good relationships with patients could be maintained through respecting patients and considering them as human beings. Through interpersonal relationships, the patient could open up and share his/her experience with the student nurses. However, it was shown that learning also depended on reciprocation between the student nurse and the patient. For instance, one student nurse said:

I've noted that if I do something on a patient, patients do something for me, because if I give care to them, they shared their needs with me, and that helped me learn a lot (Data:307).

Data display 6.1.6.3 contains further details on patients as a source of knowledge.

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**DATA DISPLAY 6.1.6.3**  
**THEME 1: DESCRIPTIVE OVERVIEW OF CLINICAL LEARNING**  
**CATEGORY 6: SOURCES AND RESOURCES OF KNOWLEDGE AND SKILL**  
**SUB-CATEGORY 3: PATIENTS AND PATIENT FILES**

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**General indicators (6.1.6.3.1)**

- ◇ Remember if the patient doesn't want me as a student to care for him, I won't learn anything, as learning depend on the patient who should tell me her problems Then I assess, plan, implement, and evaluate this patient (Data:279).
- ◇ A learning knowledge is the knowledge that we get from patients, patients' files, and all the records in the ward (Data:627).

**Maintaining good relationships with patients (6.1.6.3.2)**

- ◇ But if I am harsh to the patient because the sister was harsh to me, then I won't learn anything (Data:280).
- ◇ For patients to help me, I had to help them (Data:299).

**Knowing patients (6.1.6.3.3)**

- ◇ When I get used to the situation in the wards patients do not hesitate to share their situations with me, and as a result I learn more about conditions and I should give care to patients, (Data:568).
- ◇ This (knowing patients) helped me to remember the patients I came across in the wards, because I knew my patients, their diagnoses, it is important that to know where my patients come from their living condition at home not just in the hospital setting (593).

**Patient attitude (6.1.6.3.4)**

- ◇ From the patient's point of view, what I remember helped me learn, like if you come across a patient, who is not difficult (Data:581).
- ◇ By a not difficult patient I mean a patient who actually allows me to learn from the symptoms and signs that he has (Data:582).
- ◇ So if a patient is sort of...is willing to let himself be exposed to student, it is helpful (Data:585).
- ◇ From the positive patients, I learn from their participation because they usually share their problems with me, and as they are sharing I learn by understanding what is wrong with them (Data:591).
- ◇ From negative patients I learn that even if they are negative, I should see them as human beings who need help from me as a nurse (Data:588)

**The informed patient (6.1.6.3.5)**

- ◇ Well I find patients who know a lot about their conditions then I will learn about whatever the patient is telling me, and in that way it will help me in reaching the nursing diagnoses and managing that patient properly without actually struggling (Data:586).

**Reciprocation between student and patients (6.1.6.3.6)**

- ◇ Showing respect helped me to be more enthusiastic about my cause and me, it taught me how to care about patients as people and also taught me consideration (Data:303).
  - ◇ By consideration, I mean I've learned to consider other people, not myself only (Data:305).
  - ◇ I've noted that if I do something on a patient, patients do something for me, because if I give care to them, they shared their needs with me, and that helped me learn a lot (Data:307).
  - ◇ And during the period I felt like I am enjoying myself, then I started learning because most of the time I paid attention to what my patient wants, when I give the patient what she wants, then I realised that I have learned something (Data:427).
  - ◇ What I have experienced is that when I do nursing care, I was receiving back what I gave my patients through learning; then, I think patients are also source of my knowledge (Data:604).
  - ◇ I think I learn a lot because if I was in that patient's shoes I don't wanna be treated the same (Data:610).
-

With regards to data display 6.1.6.3 Windsor (1989:152) points out that a wide variety of clinical experiences with 'lots' of different patients with different diseases increase learning.

Knowing the patient was also seen as a source of information. Allegedly, if a student nurse knows the physical, social and emotional aspects of patients, these assist in integrating knowledge about the patient. These findings support the opinions of various researchers as discussed in section 3.4.1.4. In these studies, Tanner et al (1993:279), Radwin (1996:1142), Johns (1996:40), and Perry (2000:141) all demonstrated the importance of knowing the patient as a source and a resource of learning.

Patients' attitudes as a factor in student learning is illustrated by Daley (2001:50) who found that student nurses learned acceptance from patients as they worked with them and coming to realise their differences. Reciprocation between student and patients becomes evident during sharing relationships between a student nurse and the patient. Related research has shown that student nurses repeatedly shared not only how patients benefit from nursing care but also how student nurses benefit from these patients, therefore, it was learning about the patients' lives that student nurses found most rewarding (Beck 2000:321). If the relationship between student nurses and patients are maintained, these could serve as a good source of learning as patients can open up and share information about their conditions and nursing care needs with students.

The implications of the patient as a source of information is that student nurses should receive guidance before, and while being in the clinical field, on how to "utilise" the patient as a source of knowledge.

The discerning reader will realise that the category on sources and resources for learning also relates to teaching strategies emerging from the clinical field as discussed in section 6.2.4. In utilising these sources, appropriate teaching strategies ought to be selected; strategies such as coaching, discussions, peer support systems, questioning and modelling.

## 6.2.7 Summary

In theme 1, a descriptive overview of clinical learning was given based on related categories emerging from the data. The categories include: the concept “learning” in the clinical field, the nature of clinical learning experience, benefits of clinical learning experience, student nurses’ expectations in the clinical field, teaching strategies emerging from the clinical field, what is learned in the clinical field, and sources and resources of knowledge and skills found in the clinical field.

What emerged in this theme is that, as student nurses enter the clinical field with certain expectations including expectations relating to learning, these expectations, coupled with the teaching strategies and sources of knowledge and skill embedded in the clinical field, could both promote or hamper learning in the clinical field, depending on different factors. The learning that occurs is mainly framed by theory/practice correlation: that is either correlating theory with practice or practice with theory.

## 6.3 THEME 2: THE NATURE OF LIVED EXPERIENCE OF STUDENT NURSES

Whereas theme 1 discussed the nature of clinical learning, theme 2 addresses the nature of student nurses’ daily lived experience in the clinical field. Participants in this study found their experiences to be both positive and negative. Three general categories emerged from the data as exhibited in data display 6.2.

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<b>DATA DISPLAY 6.2</b>
<b>THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES</b>
<b>OVERVIEW</b>
◇ General indicators (Data display 6.2.1)
◇ Positive experiences (Data display 6.2.2)
◇ Negative experiences (Data display 6.2.3)

---

### 6.3.1 General indicators

Taking into consideration the existential baseline for this research, namely that whatever humans do, they “learn,” all clinical experiences of student relate to learning in some way. However, one should differentiate between “appropriate” and “inappropriate” learning resulting from appropriate and inappropriate clinical experiences, and “positive” and “negative” personal responses to these experiences.

Generally, the experiences of student nurses in the clinical field emerged as either good or bad experiences as exhibited in data display 6.2.1 below.

What enabled student nurses to have good experiences is the fact that most clinical staff were sometimes eager to facilitate learning and to work with students. This view is substantiated by a statement such as:

But the good one is that I learn about things that I've read in the book and now I do them first hand and most of the doctors are always eager to teach and are always helpful ... (Data:551).

Even though student nurses had good experiences within the clinical fields, bad experiences also occurred and were associated with inadequate guidance from trained professional staff who spelled out during learning in the clinical field that they are too busy to help student nurses. For instance, one student commented:

I just linger around not knowing what to do, and they say I must ask questions, sometimes is not easy to ask questions. I find that the sisters are too busy doing this and that and I don't really know what to ask (Data:647).

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<b>DATA DISPLAY 6.2.1</b>	
<b>THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES</b>	
<b>CATEGORY 1.: THE NATURE OF CLINICAL EXPERIENCES</b>	
<b>General indicators (6.2.1.1)</b>	
◇ Well I've had good experiences and bad experiences (Data:550).	
◇ Sometimes they"(experiences) are interesting sometimes eh--- (Data:645).	
<b>Good clinical experiences (6.2.1.2)</b>	
◇ But the good one is that I learn about things that I've read in the book and now I do them first hand most of the doctors are always eager to teach and are always helpful . . . (Data:551)	
◇ I remember her (sister) saying: "if there are some concern during my stay in this ward, where you think that we should improve or help you learn please ask us in this ward" (Data:313).	
<b>Bad clinical experiences (6.2.1.3)</b>	
◇ but there will be others (sisters) who'll just tell me to go to others because they are just too busy (Data:551).	
◇ ... most of the time we don't learn a lot in the ward(Data:645).	
◇ I find that I go there, there is no one who teaches me anything (Data:646).	
◇ I just linger around not knowing what to do, and they say I must ask questions, sometimes is not easy to ask questions. I find that the sisters are too busy doing this and that and I don't really know what to ask (Data:647).	

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With regards to "good experiences", the opportunity to integrate theory and practice as well as experiencing loyal attitudes from other clinical staff seem most important. This is supported by (Stokes & Kost 2005). Good experiences are also related to positive experiences discussed in section 6.3.2.

Student nurses also had bad experiences in the clinical field. These mostly resulted from student nurses not being guided or involved in clinical practice leaving them to kill the time “lingering.” Carlson et al (2003:35) confirm that professional personnel in the clinical field often do not have time to teach and guide student nurses. These researchers also found that student nurses were often told to go and fetch things, which they did not know where to find; and everybody was too busy to assist them. Bad experiences are also associated with negative experience discussed in section 6.3.3, further expanding this category.

### **6.3.2 Positive experiences**

Positive experiences surfaced as positive attitude, sources of joy and a sense of awareness as displayed in data display 6.2.2.

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<b>DATA DISPLAY 6.2.2</b>	
<b>THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES</b>	
<b>CATEGORY 2: POSITIVE EXPERIENCES OVERVIEW</b>	
◇	Positive attitude (Data display 6.2.2.1)
◇	Sources of joy (Data display 6.2.2.2)
◇	Sense of awareness (Data display 6.2.2.3)

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#### **6.3.2.1 Positive attitudes**

Attitudes can be defined as evaluations people make concerning objects, people or events (Werner 2003:45). These attitudes are influenced by values and they reflect people’s responses to specific situations. Positive attitudes imply not only liking, but also trying to do well in learning, to be liked by teachers and to conform to the explicit and implicit goals of learning (Lefrancois 1994:152). Lefrancois (1994:153) also points out that attitudes are subtle, pervasive, and powerful predispositions to think, act, and feel in certain ways.

Positive attitudes of student nurses definitely influence their learning. The attitudes of a student nurse are, however, also influenced by the expectations that the student nurse might have of the clinical field and the people around him/her. For instance, student nurses who participated in the current study displayed mostly positive attitudes. For instance, one of them reflected:

I expect myself to learn and achieve something from any procedure or situation, I also expect myself to search for clarity concerning how things are done so that I can be able to learn in the wards (Data:215).

Data display 6.2.2.1 reflects further evidence of positive attitudes as positive experience displayed in the clinical field.

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**DATA DISPLAY 6.2.2.1**  
**THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES**  
**CATEGORY 2: POSITIVE EXPERIENCES**  
**SUB-CATEGORY 1: POSITIVE ATTITUDE**

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- ◇ What I should think of is that sometimes bad things that are being said to students in the wards sometimes are necessary to make us study very hard (Data:205).
  - ◇ It (enjoying in the wards) makes me to have a desire to do more to my patients (Data:275).
  - ◇ I expect myself to learn and achieve something from any procedure or situation, I also expect myself to search for clarity concerning how things are done so that I can be able to learn in the wards (Data:215).
  - ◇ Learning in the units is easier when I have already spent some time (Data:412).
  - ◇ Even though I felt frustrated I used to learn and told myself that this will pass, and indeed I got used to the situation it passed (Data:424).
- 

According to Lefrancois (1994:152), attitudes are clearly affected by reinforcement. Successful students have more positive attitudes than students who are unsuccessful. Data display 6.2.2.1 shows that the desire to learn in the ward is associated with enjoyment.

Positive attitudes displayed by student nurses during the current study, demonstrate preparedness to learn and accomplish something in the clinical field. According to Werner (2003:45) if a person is satisfied with most of the factors that he/she considers relevant, the person will experience job satisfaction. If a person experiences satisfaction, positive attitudes develop and the desire to learn also develops. If a student nurse has a positive attitude, he/she is likely to develop confidence. If a student nurse has confidence in learning within the clinical field, he/she is likely to learn and be successful (Streubert 1994:30).

### **6.3.2.2 Sources of joy**

The *Readers' Digest Oxford Dictionary* (1993:823) defines joy as a vivid emotion of pleasure, extreme gladness, delight and the like. Student nurses who participated in the present study generally enjoyed being in the clinical field. What brings joy to student nurses within the clinical field includes feelings of being accepted by other staff

members, hopefulness, overcoming adversity, growth, as well as success, especially during performing presentations.

Data display 6.2.2.2 contains further evidence of sources of joy as part of students' positive experience in the clinical field.

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**DATA DISPLAY: 6.2.2.2**  
**THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES**  
**CATEGORY 2: POSITIVE EXPERIENCES**  
**SUB-CATEGORY 2: SOURCES OF JOY**

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**General indicators (6.2.2.2.1)**

- ◇ I enjoyed the presentation (Data:112).
- ◇ It makes me to enjoy being in the clinical field during every working moment (Data:149).
- ◇ If I manage to do all this things I will find myself enjoying every moment, day-by-day (Data:209).
- ◇ I enjoyed working in the wards where the sisters made me free to ask questions (Data:265).
- ◇ And during the period I felt like I am enjoying myself, then I started learning because most of the time I paid attention to what my patient want, when I give the patient what she wanted, then I realised that I have learned something (Data:427).
- ◇ I enjoyed doing admissions, during admission, I use to come across different diagnosis, different intervention instructions from different doctors, then I was to come up with my nursing diagnosis and planning what I must do (Data:462).

**Hopefulness (6.2.2.2.2)**

- ◇ If I enjoy in the wards, I feel I have a thought of peace to give me my future and hope to be a professional nurse (Data:274).

**Overcoming adversity (6.2.2.2.3)**

- ◇ Getting used to the situation influenced my learning in the sense that I've adjusted myself and start enjoying being in the ward (Data:426).
- ◇ If I become aware I find myself learning something that I did not know (Data:718).
- ◇ I feel happy especially, when our tutors from campus evaluate us and find that I know something (Data:720).
- ◇ What I should think of is that sometimes bad things that are being said to students in the wards, sometimes are necessary to make us study very hard (Data:205).
- ◇ Learning in the units is easier when I have already spent some time (Data:412).
- ◇ Even though I felt frustrated I used to learn and told myself that this will pass, and indeed I got used to the situation it passed (Data:424).

**Growth (6.2.2.2.4)**

- ◇ But generally in the wards I felt and experienced growth and my knowledge and skills also grow and I never failed in all the past three years because of the experiences (Data:210).

**Success (6.2.2.2.5)**

- ◇ From the day I successfully presented I developed a positive attitude to the sister in charge of that ward and the ward itself, and the clinical field as a whole (Data:120).

**Being accepted/Belonging (6.2.2.2.6)**

- ◇ If I feel welcomed I will be motivated to learn (Data:162).
  - ◇ if a sister in charge involves me, it shows that I am accepted member of the ward (Data:181).
  - ◇ If somebody does not involve me it means this person does not accept me as a member of the team (Data:182).
  - ◇ She even told me that I should also see myself as part of the whole staff and make learning possible, and I should be a teachable student (Data:314).
-

It is encouraging to note that some participants experienced joy through perceiving the negative comments during their experiences to be fundamental in influencing them to learn. For instance, one of them reflected:

What I should think of is that sometimes bad things that are being said to students in the wards, sometimes are necessary to make us study very hard (Data:205).

Windsor (1989:152) indicates that student nurses enjoyed clinical experiences that were considered extremely valuable and those experiences they felt were personally fulfilling to them. Student nurses who participated in the current study pointed out that they enjoyed the clinical experiences when they became aware of, and found themselves learning something that they did not know previously. Concurringly, Streubert (1994:30) states that feelings of excitement, confidence and success, pervaded the description of clinical experiences of male student nurses due to knowing that they can do something. Furthermore, to adjust, a student nurse needs to feel accepted as a member of the team; the acceptance comes from being valued and being given the opportunity to demonstrate the ability to function like a staff nurse (Streubert 1994:29).

Daley (2001:48) pointed out that the clinical field teaches nurses hopefulness which gives them the motivation to continue to look for variety of ways to deal with the issues that clients encounter. Tanner (2002:51), maintains that relationships which instill a sense of joy in student nurses involve welcoming student nurses, being helpful, and supervising student nurses as they provide care.

In conclusion, student nurses seem to have better chance of successfully learning in the clinical field if they are accepted and hopeful, and when they experience growth and feelings of achievement. From this point of view, it is expected that student nurses should be supported throughout their exposure to the realities in the clinical field by all professionals.

### **6.3.2.3 *Sense of awareness***

A sense of awareness has different, even opposing, dimensions to it. According to Benner, Hooper-Kyriakidis and Stannard (as cited in Chabeli & Muller 2004:59), a sense of awareness refers to recognition stimulated by insufficient knowledge and skills or any uncertainty in a given situation. In contrast, Gordon (1997:147) points out that one can

understand the relationship between the 'knower and the known' in terms of the knower developing *awareness* of a situation through the interpretation of experience. In the latter instance knowledge is gained whereas in the former, knowledge is lacking. In addition, *awareness* may be in terms of many different things, including the self.

The findings of the present research include that student nurses experienced awareness as it relates to self, nursing, and the clinical field as a learning area. Self-awareness involves awareness of:

- What is not known and needs to be known
- Personal weaknesses that limit one's learning
- Being other focused

According to students' experiences, one can only become other-directed once one has become self-aware.

Awareness of nursing was realised through awareness of:

- The concept of nursing
- How theory and practice are related
- Patients' beliefs and emotions as well as how to support these

Some of those interviewed also commented that they became aware of the clinical field as a learning area. This could indicate an awareness of the clinical field not as a "working" field only, but indeed as a learning field. This could form the basis of an awareness of life-long professional learning which in turn is substantiated by the existential base-line of the current research.

Data display 6.2.2.3 reflects statements on becoming aware as a disposition of the lived experiences of learning in the clinical environment.

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**DATA DISPLAY: 6.2.2.3**  
**THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES**  
**CATEGORY 2: POSITIVE EXPERIENCES**  
**SUB-CATEGORY 3: SENSE OF AWARENESS**

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**Self-awareness (6.2.2.3.1)**

- ◇ After doing the work right or after assisting the patient correctly I feel like I am becoming a nurse (Data:150).
- ◇ I knew I was short tempered, I was even aware of my weaknesses as a person which could even limit me to learn and become a professional nurse (Data:290).
- ◇ I have learned that I should be other focused (Data:296)
- ◇ Cooperation and being flexible is what I expect from myself, because if I ignore that, I won't be able to learn (Data:217).

**Awareness of what is to be known (6.2.2.3.2)**

- ◇ I have experienced that I learn to become aware of what I did not know, to have knowledge, to gain skills, to be able to help patients, and also to pass exam and become a professional nurse like other people (Data:119).
- ◇ Although in situations where there was no one to do so, I found myself doing it to be able to help the patient (Data:140).

**Awareness of "nursing" (6.2.2.3.3)**

- ◇ It is during my release period where I was allocated in hospital X where I actually understood what nursing is, by experiencing nursing by doing it on real patients (Data:457).
- ◇ But when I was in the wards I then started understanding how theory and practice were related (Data:459).
- ◇ This gives me as a student with means of becoming aware of what nursing is, beliefs of patients and how to deal with those beliefs, becoming aware of emotions of patients, and how to deal with them (Data:716).

**Awareness of the clinical environment as learning area (6.2.2.3.4)**

- ◇ I also expect myself to be available at all times, so that I get an opportunity to observe whatever happens in the ward (Data:216).
  - ◇ I have learned that in order to see the clinical field and gain the clinical experience from it, I had to accept the situation as it is because focusing on how the environment look like is not going to help me (Data:244).
  - ◇ You know, the area is so beautiful in such a way that as a student I felt like I can be in that hospital being in those wards for a long time (Data:348).
- 

In line with the existential baseline of this study, what is significant is that the notion of "self" refers to all thoughts, feelings and experiences relating to "I" or "me" and arises from biological and environmental determinants (Quinn 1995:421). Self-awareness is an outcome of introspection. According to Quinn (1995:421), introspection alone is, however, not enough to create self-awareness; an individual needs to be told by other people how they see him/her. Chinn and Kramer (1999:11) add that when people begin to share their ideas with their peers (discussed in cooperative learning, section 6.4.3), the interaction, questioning and discussion that result will bring awareness of personal insights and insights of others. These include the range of aesthetic meanings that are possible. According to Williams (2001:136), developing self-awareness should be promoted throughout nursing programmes.

Furthermore, self-awareness, reflects awareness of more than *self*; of self in relation to time and space; of self in an ontological sense; of professional growth, of nursing and the clinical environment as a learning environment. These findings support that of Kosowski (1995:238) who found that participants who were able to uncover layers of their clinical experiences with patients finally became aware of the ‘how’ of learning caring (nursing). According to Kosowski (1995:238), during interaction with clients, a transformation (personal growth) occurs as student nurses reported a new awareness of health care inequities which broadened their ability to learn caring in the clinical field. At perhaps the simplest level, one student nurse stated that she had become aware of the need to plan in order to cope with more than one demand at a time (Hislop et al 1996:176). Much of what nurse practitioners need to know is hidden in the day-to-day activity of nursing (Edmond 2001:254).

Looking at the statements on awareness, all of these have an undeniable central theme to them namely: **professional growth**. This is true of becoming aware of self as much as of becoming aware of “nursing” and of the “environment. It is correspondingly important that, all clinical staff become aware of student nurse’s multi-faceted awareness. After all, such awareness on the part of clinical staff would indicate their level of professional advancement.

### 6.3.3 Negative experiences

Data display 6.2.3 gives a summative overview of the sub-categories which compile the larger category of “negative experiences”.

<b>DATA DISPLAY 6.2.3</b> <b>THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES</b> <b>CATEGORY 3: NEGATIVE EXPERIENCES</b> <b>OVERVIEW</b>	
◇	Isolation (Data display 6.2.3.1)
◇	Demoralising (Data display 6.2.3.2)
◇	Lingering (Data display 6.2.3.3)
◇	Frustration (Data display 6.2.3.4)
◇	Copying wrong practices (Data display 6.2.3.5)
◇	Being afraid and being frightened (Data display 6.2.3.6)
◇	Being negated (Data display 6.2.3.7)
◇	Non-learning experiences (Data display 6.2.3.8)

### 6.3.3.1 Isolation

Isolation refers to separation, segregation, remoteness, loneliness as well as seclusion (Corel WP Thesaurus 1995). Participants in the current study pointed out that they experienced isolation within the clinical field. Symptoms of isolation experienced by student nurses during learning in the clinical field included a feeling of:

- Being singled out (being a scapegoat)
- Being neglected
- Having one's back being turned on you as a student nurses
- Isolation

Data display 6.2.3.1 reflects statements on isolation as a negative experience.

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<b>DATA DISPLAY 6.2.3.1</b>
<b>THEME 2: THE NATURE OF LIVED EXPERIENCE OF STUDENT NURSES</b>
<b>CATEGORY 3: NEGATIVE EXPERIENCES</b>
<b>SUB-CATEGORY 1: ISOLATION</b>
◇ I felt as if I am singled out because if professional people do wrong things as a student I don't know who to report it (Data:30).
◇ When being accepted, which makes me to learn more is prevented in the ward, as a student, I just feel like not being in the ward; this makes me visit friends in the other wards or being on sick leave (Data:163).
◇ Well, if somebody tells me that they are too busy I tend to wonder who will help me to learn because firstly, I can't just learn only from doctors because they are forever busy with patients (Data:555).
◇ I just feel isolated because in obstetrics most of the sisters are the ones who did midwifery and are the ones who know about delivering babies about examination and eich ... (Data:557).
◇ And basically they are the ones who tell me more. If they tend to turn their backs on me then is another story ... (Data:558).
◇ When I feel isolated, I feel losing interest and hope to learn, I also experience a problem in telling between my responsibility as a student and as a member of staff (Data:560).

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Participants experienced a sense of not being accepted leaving them with a feeling of increased isolation which affects learning negatively. Lefrancois (1994:313) asserts that isolation is somewhat controversial because it violates many humanistic values. To take the point further, one can argue that externally imposed isolation has grave ethical implications. Within the South African context, and without opening up a socio-political wound, isolation equates to "apartheid".

According to Dickerson et al (2000:194), students experienced a feeling of isolation where programme standards were in conflict with their cultural and personal values. In the same vein, Carlson et al's (2003: 35) research found that first year student nurses felt rejected and isolated as they perceived clinical facilitators to view them (students) as wasting their time.

When student nurses experience isolation, they also experience feelings of neither being accepted nor being received. These concepts are also humanistic and existential concepts. It seems imperative that a platform for sharing experiences of isolation be created as, ultimately, learning performance is affected negatively by both a feeling of isolation and isolation proper.

### **6.3.3.2 Demoralising**

To demoralise refers to lowering someone's spirits; make someone downhearted, to depress, deject, cast down, get down, dismay, dispirit, dishearten someone (*Readers Digest Oxford Dictionary* 1993:383). Demoralising is closely related to burnout, as student nurses who experience burnout can also become emotionally exhausted, apathetic, depressed, and bored (Schultz & Schultz 1998:398).

Being demoralised was experienced in situations where student nurses found themselves being shouted at by clinical facilitators when they made mistakes, not being involved in the clinical situation (being isolated discussed in section 6.3.3.1), and, when they experienced anger as well as when they were being belittled. Another source of demoralisation mentioned was when student nurses were forbidden to learn (to ask for guidance) from other professional staff such as doctors.

The experience of being demoralised was reflected by the indicators such as:

- Distancing, which is characterised by avoiding the unit, feelings of not wanting to do anything in the unit even to patients, feeling of completing the clinical allocation period and quickly go back to the campus
- Loss of interest and loss of hope to learn
- Sense of being unworthy
- Feeling as if a wrong career was chosen

The statements regarding experiences of being demoralised as negative experience of student nurses within the clinical field are shown in data display 6.2.3.2.

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**DATA DISPLAY 6.2.3.2**  
**THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES**  
**CATEGORY 3: NEGATIVE EXPERIENCES**  
**SUB-CATEGORY 2: DEMORALISING**

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- ◇ The sister in-charge said so many things that made me feel so unworthy of any kind of learning (Data:193).
  - ◇ I mean that without being involved I have no feeling of going to that ward and when I'm involved means being engaged in activities in the ward by sisters (Data:199).
  - ◇ It is true, every time I become angry in the ward; I felt that I don't want to do anything even to patients (Data:281).
  - ◇ I didn't even enjoy the thought of going to the ward in the morning; I felt like when are we completing our allocation period so that I can go to the campus (Data:358).
  - ◇ That makes me feel like a cheap something, as if I'm not there to learn I'm after somebody, you see--- it is demoralising sometimes (Data:669).
  - ◇ When I am demoralised, I don't feel like learning at all, I lose hope to work and learn as a student, sometimes I feel like I've chosen a wrong career, sometimes I feel like I can communicate how I feel with the sister, but on the other hand I feel I think they will not like it (Data:671).
  - ◇ The mistakes that we make sometimes have negative impact, because if the sister shouts at me after such a mistake I feel very bad and discouraged, (Data:122).
- 

Kosowski (1995) conducted a critical phenomenological study of baccalaureate nursing students regarding clinical learning experiences and professional nurse caring. The findings of this study include that while student nurses' reversed the staffs 'non-caring' behaviours, they recalled experiencing powerful emotional reactions, such as shock, disbelief, embarrassment, and sadness (Kosowski 1995:238). A student nurse who experiences shock, disbelief and sadness is likely to become demoralised. The negative effects of academic stress on the psychological well-being of students that could result in demoralisation have been widely reported. Blix et al (1994) stated that almost half of their respondents (48 per cent) reported psychological health problems resulting from work stress and that 84 per cent considered that their productivity and performance had been negatively affected (Kinman 1998:4). These authors cited depression and anxiety as the most critical stress-related symptoms reported (Kinman 1998:4). This is observable at the following levels:

- **Physical:** exhaustion, headaches, high blood pressure
- **Psychological:** the signs could be depression, anxiety, low self-esteem

- **Cognitive:** including absent-mindedness, failure of attention and memory
- **Behavioural:** absenteeism, substance abuse, aggressive behaviour

According to Kinman (1998:4), as student nurses occupy supernumerary status while being in the clinical field, any unsatisfactory practice can demoralise them. If a student nurse experiences being demoralised, loss of concentration can result as well as a loss of interest in doing assigned responsibilities. Similarly, Wong, Leung, So & Lam (2001:9) found that the most frequent complaints were "feelings of inadequacy in handling daily activities" whereby nurses felt that they could not concentrate on what they did, and were unhappy about the way things were done.

Being demoralised as a negative experience of student nurses also finds reference in the work of Mahat (1996) as pointed out in section 3.5.2. In addition, Cleigh (1972) (as cited in Mahat 1996:167) cautions that overwhelming negative forms of stress generally serve to threaten and discourage learning rather than to provide a challenge.

When student nurses feel discouraged, they are likely to be demoralised. Student nurses, during clinical placements, should be closely observed for indications of demoralisation in order to avoid students distancing themselves from the clinical situation which could further erode learning.

### **6.3.3.3 Linger**

According to *Corel WP Thesaurus* (1995), *linger* refers to hanging around, loitering, idling, and doing nothing. Student nurses found themselves lingering in situations where they expected themselves to be performing activities so that they would learn by doing. This *linger* probably relates to feelings of demoralisation (section 6.3.3.2) and isolation (section 6.3.3.1).

Factors contributing to lingering include situations where clinical facilitators are not certain of, or do not even know, student nurses' levels of advancement to be able to guide them properly. Student nurses experienced that they lingered mainly when they were still new to a clinical area, when they were not occupied (even isolated, section 6.3.3.1), or when they did not know what to do or whom to ask for guidance.

For instance, one of the participants indicated that:

I just linger around not knowing what to do, and they (clinical facilitators) say I must ask questions, sometimes is not easy to ask questions. I find that the sisters are too busy doing this and that and I don't really know what to ask (Data:647).

Data display 6.2.3.3 exhibits statements on lingering as negative experiences of student nurses within the clinical field.

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<b>DATA DISPLAY 6.2.3.3</b>	
<b>THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES</b>	
<b>CATEGORY 3: NEGATIVE EXPERIENCES</b>	
<b>SUB-CATEGORY 3: LINGERING</b>	
◇	I know that my responsibility is to use all the allocated hours to learn, but if the supervisor does not engage me as a student with the responsibility in the ward, and show me the activities, which help me learn, I find more time to move around doing nothing (Data:515).
◇	I just linger around not knowing what to do, (Data:647).
◇	In lingering I was just loitering around doing nothing instead of doing some procedures and learn (Data:649).
◇	Lingering used to happen when I was still a new person in the ward, where I had to start learning how to care for sick people, on the other hand I was still afraid to be near the staff who were there for longer time ignoring us when we wanted to be helped with some direction (Data:650).
◇	I find that I'm lingering, I find that they ask me, in which level I am? I should do this and that, and I'm not really sure whether I should really do this or that or not (Data:706).
◇	When I linger around as a student, I just idle, being unoccupied and hanging around doing nothing, especially when I'm new in the ward, and if I'm not doing anything obviously I'm not learning. Learning always takes place when a student does something in the ward, we try to tell them, but we don't really know what we should do, I just go there being empty, it's better if we can go with the clinical tutor (Data:708).

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Data display 6.2.3.3 demonstrates statements relating to lingering as a negative experience in the clinical field. Student nurses pointed out that lingering was related to being a new person in a situation where they were uncertain regarding care of patients, where student nurses were afraid (section 6.3.3.6) to be near the staff who were there for longer periods and who were ignored them. No international studies could be found in which "lingering" per se is addressed. However, various studies referred to issues bringing about lingering. Nahas et al (1999:646) found that even though Jordanian nursing students were in their second year, they experienced anxiety related to *new environments*. Carlson et al (2003:34) noted that student nurses experienced *uncertainty* related to lack of opportunities to develop competence in providing nursing care. Carlson et al (2003:35) also found that student nurses felt insecure due to a *lack of orientation* related to shortage of staff. The experience of either uncertainty or

anxiety in the clinical field, could lead a student nurse to linger around doing nothing. Linger which is an outcome of uncertainty and anxiety could be related to non-communication between the student nurse and the clinical facilitator. James, Kotze and Van Rooyen (2005:7) found that disillusionment was aggravated by non-communication or no feedback, from nurse managers about nursing care.

From the findings of the current study and literature review, there is evidence that lingering is an outcome of isolation (section 6.3.3.1), being demoralised (section 6.3.3.2) and being afraid (section 6.3.3.6). The consequences of lingering include frustration (section 6.3.3.4) which can also interfere with learning in the clinical field.

#### **6.3.3.4 Frustration**

According to *Corel WP Thesaurus* (1995), frustration refers to disappointment, dissatisfaction, irritation, annoyance, displeasure, and distress. When an organism is kept in some way from attaining its goals, the resulting frustration leads directly to aggressive behaviour as aggressive behaviour is directed at removing the obstacle in order to attain the desired outcome (Rosenberg, Wilson, Maheady & Sindelar 2004:50). In an attempt to deal with frustrations within the clinical field, student nurses displaced their frustrations to patients, shown as being harsh to patients. Hamachek (1995:463) refers to displacement as directing any angry feelings to someone else.

From the content of data display 6.2.3.4, it is evident that frustration is closely related to:

- Being a beginner
- Not being involved (isolation)
- Very ill patients
- Shortage of equipment
- Clinical facilitators who are perceived to be harsh to student nurses

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**DATA DISPLAY 6.2.3.4**  
**THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES**  
**CATEGORY 3: NEGATIVE EXPERIENCES**  
**SUB-CATEGORY 4: FRUSTRATION**

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- ◇ **Not being completely involved** really frustrated me a lot (Data:156).
  - ◇ When the **sister in-charge** was somehow frustrating to me, at times I found myself being harsh to my patients (Data:276).
  - ◇ From the start, when I reach across a **very ill patient**, eish--- it was frustrating (Data:417).
  - ◇ These experiences (frustration) influenced my learning in a negative way, because I didn't feel like **communicating** with such a sister anymore, the thought of being in that ward made me to have headache (Data:497).
  - ◇ I remember while being in the ward, where the patient was having a swelling in the legs, the school taught us to raise the feet of this patient, but there was no bed elevator nor enough pillows, then I became frustrated because much as I wanted to do what was best for my patients, I didn't achieve as there was **shortages** of equipment (Data:750).
- 

The experience of frustration, as indicated by data display 6.2.3.4, figures in student nurses becoming harsh towards patients, and in distancing themselves from clinical facilitators as sources of learning as discussed in section 6.2.6. According to Potgieter (2003:213), the frustration/aggression hypothesis explains the dynamic that causes an employee (a student nurse) to lash out verbally or physically at other people (patients) or objects. Potgieter (2003:213) points out that people (student nurses) who are frustrated normally react in three ways:

- **Verbal aggression:** verbally lash out at others
- **Physical aggression:** damage to work equipment and or more seriously, violence towards others
- **Internalised aggression:** through bottling up frustration which may lead to depression and anxiety

Sources of frustrations in the clinical field also include problems related to time management. According to Windsor (1989:151), time management is a major source of frustration as inadequate time management left student nurses feeling disorganised. According to Wilson (1994:83), student nurses, who strongly identify nursing with highly visible psycho-motor skills, express frustration over what they perceive as inadequate skill practice. Kosowski's (1995:239) found that student nurses have a strong desire to intervene during episodes of non-caring, but often felt intimidated and powerless in their roles. The perceived powerlessness augmented their feelings of anger and frustration.

Inappropriate patient selections (for assignments) can also be a frustration for student nurses (Fothergill Bourbonnais & Higuchi 1995:40). Other issues that appear to cause helplessness and frustration to student nurses are shortages of staff and equipment to fulfil nursing duties (Carlson et al 2003:34).

The relationship between frustration in the clinical field and physical illness find reference in the work of Dickerson et al (2000). Student nurses indicated that they actually got sick from trying to deal with the stress of learning within clinical fields (Dickerson et al 2000:192).

Frustration also correlates with expressed feelings of fear related to caring for dying patients. According to Daley (2001:51), participants reported that at first, the losses were difficult to deal with. But as they adjusted themselves, student nurses also described how they learned to be hopeful about life, when they saw people who die tragically (Daley 2001:48). Hopefulness is described in section 6.3.2.2.

The experiences of student nurses' frustrations within the clinical field, with regard to dealing with patients who are suffering, demand thorough orientation of student nurses before allocation to dealing with these patients. This may take the form of thorough orientation and accompaniment so that student nurses could feel supported during such experiences. When student nurses feel supported, the experience of frustration is likely to be reduced.

#### **6.3.3.5 Copying wrong practices**

Copying refers to impersonating, trying to be like, and imitating (*Corel WP Thesaurus* 1995). Therefore, copying wrong practice, means imitating and learning incorrect practices in the clinical field.

Data display 6.2.3.5 reflects statements on copying wrong practices as negative experiences during clinical learning. According to those who participated in the current study, even though student nurses could resist imitating wrong practices, as they get used to the situation, they automatically find themselves identifying with such practices. The findings of the current study also indicate that student nurses experience anxiety

and fear when they perform procedures incorrectly or wrongly. This fear and anxiety are amplified when others in the clinical field judge them negatively for this. As one participant said:

If I practice things wrongly other people will always say: this person did not learn anything because what she is doing is wrong (Data:34).

This statement is further significant in light of the fact that participants also indicated that learning could come about even through making mistakes. *Judgement* that impacts negatively on student learning may annul this positive element of making mistakes. It may also lead to student nurses becoming afraid to attempt new skills causing a negative learning spiral.

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**DATA DISPLAY 6.2.3.5**  
**THEME 2: THE NATURE OF LIVED EXPERIENCE OF STUDENT NURSES**  
**CATEGORY 3: NEGATIVE EXPERIENCES**  
**SUB-CATEGORY 5: COPYING WRONG PRACTICES**

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- ◇ When the clinical facilitators call patients by their diagnose, it made me feel like I am learning the wrong practice, although some of us as students we did copy such practices, from the first week, we were afraid to call patients with their diagnoses, but second week, then we found ourselves calling patients by their diagnoses (Data:31).
  - ◇ If I practice things wrongly other people will always say: this person did not learn anything because what she is doing is wrong (Data:34).
- 

Student nurses are able to judge whether what they learn in the clinical field is incorrect. This is done, either, as the participant indicated (Data:31), because clinical practice differs from theory gained at the college, or because of the effect of “abstract modelling ... the process whereby the observer elicits the principles of behaviour from a variety of modelled stimuli and applies it to a situation similar to the ones which were observed” (Quinn 1995:98).

The student nurse could become discouraged and confused about the differences between what was learned in theory versus the practice within the clinical field and when a discrepancy is observed between what is professed to in clinical practice and what is actually being done.

### **6.3.3.6 Being afraid and being frightened**

Fear is an immediate alarm reaction to current danger (Mash & Wolfe 2005:183). According to Palmer (1999:7), in colloquial usage the word *fear* has been replaced by the word *anxiety*. Furthermore, something known can be feared and something unknown causes anxiety. This suggests that there is a 'prevailing presence' of anxiety in all situations where threat is intangible such as in the clinical field.

Data display 6.2.3.6 reveals that student nurses experienced being afraid and being frightened in the clinical area.

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<b>DATA DISPLAY 6.2.3.6</b>
<b>THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES</b>
<b>CATEGORY 3: NEGATIVE EXPERIENCES</b>
<b>SUB-CATEGORY 6: BEING AFRAID AND FRIGHTENED</b>
<b>Being afraid (6.2.3.6.1)</b>
◊ What I have experienced is that once the sister becomes too serious, we (students) become afraid to ask questions (Data:407).
◊ Sometimes I find that well me as a person, I don't know how to rephrase the question or I'm just afraid to do that (Data:652).
◊ I was still afraid to be near the staff who were there for longer time ignoring us when we wanted to be helped with some direction (650).
◊ My heart was pounding because of being afraid to present and also to make mistakes during presentation (102).
<b>Being frightened (6.2.3.6.2)</b>
◊ Seeing patients being very ill without waking up, others dying, eish--- it was so frightening (Data:417).

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Findings of the current study as displayed in data display 6.2.3.6 correlate with those of Kleehammer et al's (1990) study regarding nursing students' perceptions of anxiety-producing situations in the clinical setting. In the study, student nurses reported the fear of making mistakes as the highest anxiety-producing source (Kleehammer, Hart & Keckl 1990:186). The concept "learning error" (Alfaro-LeFevre (2004:222) also applies in this instance. Learning errors are usually related to "several different factors associated with being in a learning situation." One way of avoiding learning errors is not to attempt any new skill. This is, however, impractical and merely postpones the inevitable (Alfaro-LeFevre 2004:222) as mistakes cannot be completely eliminated. Learning error can however be limited by practicing in, and gaining, an acceptable level of expertise in simulated circumstances (laboratory) before executing procedures in the real clinical setting.

Further with regard to “being afraid” and “being frightened,” Zerwekh (2000:51) reports that what is unfamiliar during patient care, makes nurses feel at least “uncomfortable.” Little (2000:395) further states that anxiety could be provoked by a scene of a patient amidst multiple equipment; or equally, upon the first sight of unfamiliar equipment. This also increases the possibility of learning error (Alfaro-LeFevre 2004:222).

Increasing acuity in most clinical fields terrifies beginning student nurses (Tanner 2002:51). If student nurses experience uneasiness, fright or being afraid in the clinical field, this might influence learning negatively. Taken into consideration the nature of nursing and health care in the clinical field, it can be assumed that student nurses often enter the clinical field with a certain degree of apprehension towards making mistakes, being failures and being frightened in the clinical situation. For this reason clinical briefing and debriefing sessions are of the utmost importance to sustain clinical learning. White and Ewan (1991:89) state that the major purpose of *briefing* is the preparation of students for learning in clinical fields, and the activities of a clinical assignment as well as for preparing for experience to relieve fear and being afraid. According to Hart and Rotem (1994:30), debriefing sessions provide an opportunity for student nurses to discuss their experiences, to critically examine their own performance and to offer feedback to peers. This could reduce fear and being frightened. Quinn (1995:423) asserts that one should avoid forcing feedback on someone about a negative aspect of his/her behaviour. It is also vital to avoid global condemnation of someone as a person thereby increasing fear rather than reducing fear. In this regard also see section 6.5.3.3 on clinical tutors’ pre-occupation with students making mistakes as an erosive factor to clinical learning.

#### **6.3.3.7 *Being negated***

Being negated refers to being annulled, invalidated, unacceptable, worthless, insupportable and intolerable (*Corel WP Thesaurus* 1995). The statements contained in data display 6.2.3.7 relate to the experience of being negated during clinical placements. Negation may precede lingering (section 6.3.3.3), the feeling of being unworthy, as well as anxiety.

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**DATA DISPLAY 6.2.3.7**  
**THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES**  
**CATEGORY 3: NEGATIVE EXPERIENCES**  
**SUB-CATEGORY 7: BEING NEGATED**

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- ◇ ... the theatre sisters use to prefer to allocate an enrolled nurse to assist during operation even where the operations were minor ones where I felt that if I can also be allocated I could learn something (Data:154).
  - ◇ Even communication with a student was not effective ... they don't listen to us (Data:159).
  - ◇ I would go to the nurses home and sleep without anybody realising that I am not in the ward (Data:498).
  - ◇ When me and my friend followed that sister to learn something, when I reach that sister, sister said "mm-mm-no, if you want to give medicine, you must yourself go and take the medicine trolley, not to wait for me as a sister to take the medicine trolley ....' (Data:322).
  - ◇ ... no one care whether we are in the wards or not, they don't even know our names (Data:488).
  - ◇ When I talked to these sisters and they kept quiet, the assistant nurse will tell me not to worry about that as the sister is doing that to every one not me alone (Data:496).
  - ◇ Sometimes as a student neh--- I want to be like motivated, being pushed to learn, sometimes the sisters at the clinic, they just leave me like that ... (Data:732).
  - ◇ Doesn't have time to explain this and that, and sometimes sisters do not give me that chance to be next to the doctor, they just--- (laugh) they just say "you won't" (Data:665).
- 

The contents of data display 6.2.3.7 finds reference in the work of Hart and Rotem (1994:30) who indicate that in the study they conducted some staff members were hostile and hung around student nurses too much or left them completely alone. Student nurses also felt that their lack of knowledge was exaggerated in the clinical field even when they began to define their credibility as nurses (Attridge 1996:410). In other words, whatever these student nurses were trying to accomplish was not accepted. As indicated in section 6.3.3.2 this could lead to demoralisation and influence learning in the clinical field negatively.

### **6.3.3.8 *Non-learning experiences***

Although "non-learning" is a logical impossibility in terms of the existential base-line of the present research, students saw certain tasks they were assigned as "non-learning" experiences. The "non-learning" nature of these experiences points towards them not contributing towards attaining the outcomes set for students during their clinical placements. Participants also felt that what was assigned to them often contradicted the outcomes set to be attained during their clinical placements. It is alleged that clinical facilitators enjoyed sending them to perform non-learning tasks such as going to the

tuck shop, matron's office or carrying messages to their colleagues. All of these can also result in students feeling negated (section 6.3.3.7); that their status as learners and future professional are being negated. On the other hand, some student nurses experienced non-learning tasks positively as discussed in section 6.2.1.2 on learning versus work.

Data display 6.2.3.8 exhibits evidence relating to non-learning tasks and experiences such as:

- collection of facilitator's personal items
- working like porters or messengers
- being seen as an extra staff member

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**DATA DISPLAY: 6.2.3.8**  
**THEME 2: THE NATURE OF LIVED EXPERIENCES OF STUDENT NURSES**  
**CATEGORY 3: NEGATIVE EXPERIENCES**  
**SUB-CATEGORY 8: NON-LEARNING EXPERIENCES**

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- ◇ The opportunity was disturbed because the sisters in the wards just enjoyed to send us out from the wards to go and collect treatment in the dispensary (Data:467).
  - ◇ At times they will say: "go and give the matron this form and she signs, or give sister so and so this catalogue or buy bread in the tuck shop", even though some of the things are personally (Data:468).
  - ◇ Being sent to collect something that is personal, affect me negatively because I spend my time just rooming around in the corridors to collect things, working like a porter or a messenger (Data:476).
  - ◇ This is related to my learning because as a student nurse, I have noticed that the sisters do not differentiate learning and care for the patient (Data:766).
  - ◇ It seems as if when the sisters see students in their wards they see extra staff members to come and relieve the shortage (Data:769).
- 

Baillie (1993:1047) indicates that there is often discomfort surrounding the role of the student which does not make student nurses feel useful or valuable. Carlson *et al* (2003:36) affirm that student nurses spend a lot of time performing non-nursing activities (non-learning experiences) that prohibit them from developing adequate nursing skills. The non-learning experiences pointed out in Carlson *et al*'s (2003) study include assisting and carrying out functions that are not within the scope of the practical programme. The scope of student nurses' practical programme is outlined in Regulation R425 according to SANC (1985) as amended, which stipulates the subject curriculum of the four-year comprehensive programme, which is discussed in section 3.3.3.2.

There is, however, a positive side to participants' complaints about non-learning experiences namely that they have other, higher expectations of their clinical exposure. These expectations are discussed in section 6.2.3. Nonetheless, stakeholders involved in learning of students within the clinical field should establish a clear common understanding of learning experiences and non-learning experiences. There is a need to identify clearly what learning entails while also doing routine work in the clinical field. For instance, if a student really needs to go to the dispensary, the student also needs to be informed why, within the overall outcome of learning and professional socialisation, he/she has to do it at that very moment. The motivation must relate to the outcomes set for learning in the clinical environment.

#### **6.3.4 Summary**

In section 6.3 theme 2 on the nature of the lived experiences of student nurses (in the clinical field) was substantiated by several sub-categories within two broader categories of "positive" and "negative" experiences. In theme 3 (section 6.4), it is indicated that motivational factors, in addition to positive personal experiences, promote learning in the clinical field.

### **6.4 THEME 3: MOTIVATIONAL FACTORS IN CLINICAL LEARNING**

According to Louw and Edward (1998:424), motivation refers to the fact that people actively look for or move towards specific kinds of experiences. These authors further state that motivational processes make individuals seek and find things that they need to know and do. James et al (2005:9) expand on this definition through pointing out that in motivation, expectations are taken into consideration.

Motivation also refers to the force within an individual that *arouses*, directs and sustains his/her behaviour (Bagraim 2003:52). Bagraim (2003) further explains that "arousal", is about the energy that drives an individual's behaviour. For instance, a student nurse's behaviour in the clinical field could be guided by the desire to learn and gain knowledge and skills and be successful in his/her nursing career. The second part of this definition is about "choices" that an individual makes between different behaviours to achieve a goal and the direction of that behaviour. For example a student nurse can choose between different behaviours that he/she thinks may help to create a good impression,

which is, being a good role model (section 6.2.4.7). The third part of the definition is concerned with how long an individual is “willing” to persist and attempt to meet his/her goal to sustain his/her behaviour. For example if a student nurse gives up creating a good impression after little effort, he/she cannot describe him/herself as being a highly motivated student (Bagraim 2003:52).

Motivational factors that promote learning in the clinical field as they emerged from the data are displayed in data display 6.3.

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<b>DATA DISPLAY 6.3</b>	
<b>THEME 3: MOTIVATIONAL FACTORS</b>	
<b>OVERVIEW</b>	
◇	Praise as a potential motivator (Data display: 6.3.1)
◇	Availability of nurse educators (Data display: 6.3.2)
◇	Cooperative learning (Data display: 6.3.3)

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Hamachek (1995:278) is of the opinion that when a student nurse works hard to win favour or to gain praise from a teacher it can be concluded that this motivation is extrinsic. If the student, however, does things in order to develop, to help patients and to learn, his/her motivation may be considered to be *intrinsic*.

Extrinsic motivational factors emerged from the data as *praise* and as the availability of a clinical tutor. Intrinsic motivation during the current study emerged in cooperative learning, however, there is also an extrinsic aspect to cooperative learning.

#### **6.4.1 Praise as a potential motivator**

Data display 6.3.1 exhibits evidence on praise as an external motivational factor. Praise was shown through verbal comments such as “good” or “perfect”; and facial expressions accompanied by smiles, when student nurses carried out a given assignment or did a task well

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<b>DATA DISPLAY 6.3.1</b>	
<b>THEME 3: MOTIVATIONAL FACTORS</b>	
<b>CATEGORY 1: PRAISE AS A POTENTIAL MOTIVATOR</b>	
◇	When the sister was saying good, I felt good about the praise, and I felt more encouraged (Data:107).
◇	... with somebody who has experience to ... tell me actually that I am in the right direction (625).

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According to Moloney 1992:295), motivation strengthens commitment and can be activated daily by individuals as they consciously strive towards professionalism. Moving from esteem needs to autonomy and ultimately to self actualization, in terms of Maslow's hierarchy of needs, will enable nurses and students to become self-motivated requiring little or no supervision (Moloney 1992:296) and consequently self-directedness (section 6.2.5.7).

It can be assumed that student nurses, in the clinical field, are motivated by a strong achievement drive to learn more after they have been praised. The findings of the present study are in line with McClelland's (1962) Achievement Theory as described in Moloney (1992:294) and Bagraim (2003:58). According to these authors, McClelland (1962) and colleagues conducted considerable research on the achievement motives which can be acquired through training and which is not genetically produced. McClelland (1962) believes that persons high in the achievement motive (an Ach motive), possess a specific type of human motivation and strongly prefer working situations where feedback can be readily obtained. It appears that as the achievement motive increases so does the likelihood that the student nurse could learn and gain knowledge and skills as well as greater power and responsibility.

In keeping with the achievement theory, Hart and Rotem (1994:28) found that student nurses appreciated recognition from staff members for their contributions to patient care and were consequently disappointed when their work was not acknowledged verbally. There are at least two factors involved in achievement, the need for success and fear of failure (see section 6.3.3.6) that are both present in student nurses (Quinn 1995:21). If motivation is predominantly the need for success, then the student nurse is likely to keep trying in the event of initial failure, but encouraged by initial success. Student nurses with a high motivational achievement (Ach) will benefit from more challenging assignments, while those with a low "Ach" benefit from less challenging assignments (Quinn 1995:21).

Other aspects that acted as motivational factors found in the reviewed literature include: positive feedback about student nurses' performance from clinical tutors (Windsor 1989:152); giving awards and rewards (Massarweh 1999:44); and realising the potential of employees (Jooste 2003:96). Hamachek (1995:279) cautions that if student nurses

are preoccupied with external (rewards and praise) sources of motivation, they might not appreciate the value of what they might be learning.

#### **6.4.2 Availability of nurse educators**

Data display 6.3.2 addresses statements concerning the availability of a nurse educator as an extrinsic motivational factor.

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<b>DATA DISPLAY 6.3.2</b>	
<b>THEME 3: MOTIVATIONAL FACTORS</b>	
<b>CATEGORY 2: AVAILABILITY OF THE NURSE EDUCATOR</b>	
◇	It is actually important that tutors actually go into the ward because if I see them coming I become motivated to learn (Data:612).
◇	Sometimes as a student neh--- I want to be like motivated, being pushed to learn, sometimes the sisters at the clinic, they just leave me like that if I don't work with them (Data:732).

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According to Neill et al (1998:19), the student nurses who participated in their study demonstrated the importance of connecting to mentors in order to develop and learn in the clinical field. Connecting is discussed in section 6.2.5.5. In a study conducted by Carlson et al (2003:38), student nurses indicated that because they were new in the clinical field, they needed somebody to '*check*' them whilst rendering patient care and practising skills. According to Du Plessis (2004:68), through accompaniment, student nurses learn to act independently as professional practitioners who deliver a high standard of quality nursing care. The availability of nurse educators in the clinical field as a motivational factor is closely related to the expectations of student nurses regarding being with a clinical tutor in section 6.2.3.5. Either a clinical tutor or a nurse educator can use the didactics emerging from the clinical field as discussed in section 6.2.4 to facilitate motivation in student nurses. In addition, invitational learning described in section 6.2.4.4 applies.

#### **6.4.3 Cooperative learning**

Cooperative learning refers to an association of student nurses with one another, for mutual or common benefit in learning (Hamachek 1995:306). According to Robinson (1990 as cited in Porter 2000:267) cooperative learning involves highly structured group activities in which students rely on each other to achieve a common goal and common

reward. Cooperative learning could also take place in the clinical field where student nurses are allocated in small numbers and being rotated in various wards. According to Porter (2000:267), groups need to be small enough so that members can get to know each other personally and groupings should change regularly in order for rivalry not to build up between groups. For practical purposes, cooperative learning can be viewed as a learning method where students work together in small groups to learn and are responsible for their team mates' learning as well as their own. In a cooperative learning environment, students work in groups of two to six to achieve a common goal. Cooperative learning is seen as a powerful tool to motivate learning.

Cooperation with both clinical tutors and peers in learning is evident from the data units exhibited in data display 6.3.3. The data indicate that student nurses were motivated to learn through cooperative learning; and the exchange of knowledge and skills with one another that were obtained in other clinical areas. For instance, one interviewee said:

Since we are grouped in a small groups, if I insert a catheter now, the next time is their turn, and well in that way we do things as a group, but at the same time I also get a chance to do something myself (Data:569).

Cooperative learning as a motivating factor emerged as:

- information exchange
- problem-solving
- practising procedures
- self-evaluation
- discussion

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**DATA DISPLAY: 6.3.3**  
**THEME 3: MOTIVATIONAL FACTORS**  
**CATEGORY 3 COOPERATIVE LEARNING**

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**Information exchange (6.3.3.1)**

- ◇ Like if I learn something during the other shift when I arrive I tell her (fellow student nurse) that I've learned one, two, and three things; and she will also tell me about her experiences in her unit (Data:506).
- ◇ If she is in maternity ward she (student nurse) come and tell me about midwifery, and if I am in the general ward I explain about the general patients (Data:511).

**Problem-solving (6.3.3.2)**

- ◇ When I am with a group of other students, I learn that when I am faced with a problem, how best can I find a solution, and if a patient is having a problem, how I can get the patient out of this problem (Data:573).
- ◇ Being with my classmates, we have helped one another to try out the ways to improve our patient care (Data:575).

**Practising procedures (6.3.3.3)**

- ◇ Since we are grouped in small groups, if I insert a catheter now, the next time is their (student nurses) turn, and well in that way we do things as a group, but at the same time I also get a chance to do something myself (Data:569).

**Self-evaluation (6.3.3.4)**

- ◇ Well as well as in a group we do things ourselves, we self evaluate ourselves, testing how much we understand as a group, and then we also form small group discussion to discuss what ever that we've learn during that day (Data:570).

**Discussion (6.3.3.5)**

- ◇ After when we go home we meet then we combine we discuss everything that we've done during the day, as long as the sisters and doctors give us ward tasks like assignment so that we go do it at home the following day we'll go discuss that with the doctor as a group, or with the sister as a group (Data:571).
- 

According to Girot (1993:116), student nurses need to develop the ability to do self-assessment as well as to be assessed. According to An Bord Altranais (2003:7), learning must be active and interactive in order to question and to be questioned to increase insight and understanding.

The findings of the current study are also corroborated by Dickerson et al (2000:190) who found that a key factor in student nurses' learning in the clinical area is cooperative participation instead of competition. Furthermore, Dickerson et al (2000: 193) mentioned that Native American student nurses supported each other through:

- Joining groups to gain knowledge and to learn in-groups
- Interacting in groups
- Confiding in, and informing each other of potential problems
- Sharing survival skills and expectations
- Supporting and mentoring each other because they all had a common bond

- Evaluating themselves (as students) to test their level of understanding

According to Quinn (1995:183), by planning for two or more student nurses to work together, there can be substantial benefits for both, provided they take time to discuss approaches and decisions and their underlying rationale. If student nurses study together and support each other they are more likely to be successful in their learning (O'Banion 1997:55). Having student nurses discuss specific ambiguous situations they encountered; and strategies used to effectively address the ambiguous situations can help other student nurses to develop both a more realistic view of health care and a sense of empowerment in addressing ambiguities (Taylor 2000:174). The importance of cooperative learning is also emphasised by Fisher and Gaines (2001:147). According to Gaines (2001:147), promoting team work requires that all student nurses in the group perceive that even though they are individually accountable for their own performance, no student nurse can succeed unless everyone else does. Fisher and Gaines (2001:207) corroborate this by asserting that in a group student nurses learn to hold one another accountable for assignments because the entire group is dependent on all members pulling their weight. Furthermore, students liked being put into small groups so that they could get to know one another (May, Hodgson & Marks-Maran 2005:5).

Summatively, cooperative learning can be used to:

- encourage greater achievement
- foster positive attitudes and higher self-esteem
- to develop collaborative skills
- to promote greater social support

#### **6.4.4 Summary**

From theme 3 on “motivational factors”, factors that could improve learning in the clinical field and learning of student nurses within the clinical field include: praise, availability of the nurse educators and cooperative learning. Central to these is a sense of being accepted in the clinical environment. Naturally these are not the only motivating factors present in the clinical field, other categories that also contain motivational factors such as sources of joy are explained in section 6.3.2.2.

## 6.5 THEME 4: EROSION FACTORS IN CLINICAL LEARNING

In contrast to motivating factors in the clinical field, there are also factors in the clinical field that erode students' learning. Erosive factors most profoundly experienced by student nurses are things perceived to be inappropriate or threatening to the self or whenever they were frustrated in their quest to learn. The evidence exhibited in data display 6.4 also returns the reader to the sub-categories on the negative experiences of student nurses in the clinical field (section 6.3.3).

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DATA DISPLAY 6.4	
THEME 4: EROSION FACTORS IN CLINICAL LEARNING	
OVERVIEW	
◇	Allocation to and in the clinical field (Data display 6.4.1)
◇	Student nurses' attitudinal issues (Data display 6.4.2)
◇	Student nurses' perceptions of clinical facilitators (Data display 6.4.3)
◇	Environmental as an erosive factor (Data display 6.4.4)

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Erosive factors of learning in the clinical field include:

- assignment of responsibilities
- student nurses' attitudes
- clinical facilitators' attitudes
- environmental factors

### 6.5.1 Allocation to and in the clinical field

Data display 6.4.1 contains data indicating aspects of student allocations to the clinical field, and allocations within the clinical field that they experienced as erosive to, or as obstructing learning. Areas that emerged specifically as problematic include: group allocation, night duty and the allocation of non-learning tasks (see section 6.3.3.8).

**Group allocation** has implications with regards to cooperative learning as discussed in section 6.4.3. The overall message from the participants is that if too many student nurses of the same level of advancement are allocated in one ward, sharing experiences from various units becomes impossible and learning is thereby eroded. Therefore, if student nurses of the same year group are allocated to different wards their ability to share and discuss learning experiences among themselves enable them to learn more. It must, however, also be pointed out that allocating two or more student

nurses of the same level of advancement to the same clinical area might provide these students with an opportunity to share their knowledge and skills thereby enhancing cooperative learning.

Prolonged periods of working **night shifts** were also experienced as an erosive factor to learning within clinical fields. In addition to the long working hours and the unnaturalness of working night-shifts, students become tired of performing the same tasks. These issues also relate to the category on learning and working (see section 6.2.1.2). This could ultimately result in, as one informant indicated, student nurses getting tired of repeating the same tasks every night in the ward. A statement that indicates this experience reads:

7 to 7 (19:00 to 07:00) makes me learn through repeating similar activities, whereby if I know these activities I don't gain anything new (Data:632).

Student nurses were also concerned about being commanded to do just any **tasks regardless of their level of advancement** whereby their learning outcomes were not being considered. Assigning student nurses to do just anything and everything without consideration of their level of training, erodes learning. This is also related to non-learning experience as discussed in section 6.3.3.8.

The effects of this kind of assignment on student nurses include:

- the feeling of not learning new skills
- feeling as if one is made to patch up staff shortages
- feeling of being exploited
- association of skills which had already been achieved by working and not by learning as discussed in sections 6.3.3.8 and 6.2.1.2.

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#### DATA DISPLAY: 6.4.1

#### THEME 4: EROSIIVE FACTORS IN CLINICAL LEARNING CATEGORY 1: ALLOCATION TO AND IN THE CLINICAL FIELD

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##### Group allocation (6.4.1.1)

- ◇ But if they allocate us as a group I become demotivated because I don't compete with anybody (Data:508).
- ◇ If they allocate all of us in the same ward, what I know is what my colleague is already experiencing in that unit, then we won't share the differences and I won't learn (Data:510).

##### Night shift (6.4.1.2)

- ◇ And one of my worst experience is when I have to work long hours of night duty from 7 to 7 in the morning (Data:19h00 to 07h00), and my role is to take patient's vital signs like I take blood pressure, temperature, pulse the whole night, and I don't see this as a learning experience because if I keep on repeating over and over I actually got tired of doing the same thing, I should be allocated to put up drips, catheters, it shouldn't be constant thing (Data:630).
- ◇ 7 to 7 (Data:19h00 to 07h00) makes me learn through repeating similar activities, whereby if I know these activities I don't gain anything new (Data:632).

##### Non-specific tasks (6.4.1.3)

- ◇ According to me, when I go off at 19h00, I expect that I should be assigned some other activities, like ordering diet, stationery, compiling nursing care plans in the morning, so that in the evening I can then wheel a medicine trolley and give medication; but we are allocated to do what they want (Data:46).
  - ◇ I can learn from working only if what I am doing is new, but if I am repeating what I am doing everyday, like bed bath daily, that is not learning (Data:764).
  - ◇ What I have learnt from using students to relieve shortage is that, what we should be learning as per learning objectives are not considered, as a student, I'm just being allocated to do anything in the ward without considering the reason for allocation (Data:771).
- 

The evidence in data display 6.4.1 is also supported by literature. The potential irony implied is that student nurses anticipate that learning activities take precedence over other ward activities (Little 2000:393). In addition, Naude et al (2000:125) point out that student nurses who are allocated to do night duty during the first six months of their first year of training, experience a lot of anxiety and fear.

From the evidence in data display 6.4.1 it seems that student nurses did not realise that certain repetitious tasks are vitally important and that learning is enhanced by repeating certain activities. This again relates to non-learning activities (sections 6.3.3.8) and learning versus work (sections 6.2.1.2). Edmond (2001:253) is of the opinion that the ability to read a particular situation, whilst at the same time monitoring all other patient related activities, and to interpret the subtle signs of psychosocial needs and knowing when and how to respond appropriately, can only be constructed through repeated experiences in practice settings.

Assignment of **tasks** also finds reference in the study conducted by Attridge (1996:140) who found that students were bombarded constantly with expectations for practising

their hospital role, an area of performance they perceived their programme did not emphasise, and an area of performance for which they felt ill prepared. Similarly, Kinman (1998:10) found that the lack of clearly defined boundaries created an additional cause for concern and a source of stress. Wong et al (2000:4 indicate that nurses felt that work schedules were determined by crises rather than by planning which contributed to stress. Mey (2001 cited in Potgieter 2003:102) indicates that a lack of clear roles, responsibilities and accountabilities can result in disorganisation and conflict. These findings are related to the results of the present study in the sense that whatever contributes to stress in nurses in general, can also be an erosive factor to the learning of student nurses in the clinical field based on supernumerary status as discussed in section 6.5.2.5.

It emerged from the findings of this study that student nurses' perceptions are that they are being considered as a workforce rather than as students whereby work-related practices receive attention over their learning outcomes. Through this perception, student nurses overlook a very important aspect of their learning. For instance, bed baths are not only for personal hygiene but also an opportunity to evaluate the patient's progress/regress and to observe signs and symptoms. Student nurses might have an inherent "hierarchy" of both skills and student status that relate to their personally felt importance. If this is the case, then being "qualified" might indicate that one has advanced beyond any practicality and that one, as is the case often, has *arrived*. Nonetheless, when a task is assigned to a student nurse, briefing about his/her role and responsibility is necessary. Briefing was highlighted in section 6.3.3.6 (being afraid and being frightened).

### **6.5.2 Student nurses' attitudinal issues**

Data display 6.4.2 gives an overview of sub-categories relating to student nurses' attitudes as an erosive factor in clinical learning. These categories should also be read in conjunction with section 6.3.3 and data display series 6.2.3.1 through 6.2.3.8 on student nurses' negative experiences in the clinical field.

Attitudinal issues that could erode learning in the clinical field as these emerged from the data are listed in data display 6.4.2.

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**DATA DISPLAY 6.4.2**  
**THEME 4: EROSION FACTORS IN CLINICAL LEARNING**  
**CATEGORY 2: STUDENT NURSES' ATTITUDINAL ISSUES**  
**OVERVIEW**

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- ◇ Hostility (Data display: 6.4.2.1)
  - ◇ Lack of the student's personal responsibility (Data display: 6.4.2.2)
  - ◇ Negative perception of clinical staff (Data display: 6.4.2.3)
  - ◇ Retaliation (Data display: 6.4.2.4)
  - ◇ Status of students in the clinical area (Data display: 6.4.2.5)
- 

### **6.5.2.1 Hostility**

Hostility refers to antagonism, resentment, aggression, conflict and friction (*Corel WP Thesaurus* 1995).

Data display 6.4.2.1 contains statements that might indicate hostility experienced by student nurses during learning in the clinical field. Participants became aware of the following:

- tendency to dislike ideas, advice or guidance from specific clinical facilitators
- inability to gain information
- sitting without doing practical activities
- being short tempered

It can be delineated from the results of this study that hostility of student nurses during learning in the clinical field could be as a result of bitterness towards facilitators within the clinical field. This is identifiable when an interviewee said:

These experiences influenced my learning in a negative way, because I didn't feel like communicating with such a sister anymore, the thought of being in that ward made me to have headache (Data:497).

Data display 6.4.2.1 exhibits statements on hostility as an erosive factor in learning in the clinical field.

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**DATA DISPLAY: 6.4.2.1**  
**THEME 4: EROSIIVE FACTORS IN CLINICAL LEARNING**  
**CATEGORY 2: STUDENT NURSES' ATTITUDINAL ISSUES**  
**SUB-CATEGORY 1: HOSTILITY**

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- ◇ I had experience that if I have negative attitude toward a specific sister, I also have a tendency of disliking any idea, advice or guidance from the sister and actually I even dislike the unit (Data:124).
  - ◇ I had a patient's file in my hand, so I put that patient's file down and went out (323).
  - ◇ And we told our selves that anyway giving medication to the whole ward is too strenuous, if she doesn't want us to help her it is her problem not students' problem (Data:327).
  - ◇ But if the sisters in the ward have such (not allowing student to follow them and learn) reactions it interferes with learning-teaching relationship (Data:328).
  - ◇ These experiences influenced my learning in a negative way, because I didn't feel like communicating with such a sister anymore, the thought of being in that ward made me to have headache (Data:497).
  - ◇ As a student, I just look at the sister and tell myself inwardly that this sister is selfish (Data:530).
  - ◇ I just don't work if the sisters are not working just to make them to be aware that what they are doing is completely wrong (533).
- 

Evidence of hostility is found in the work of Paterson and Groening (1996) regarding teacher-induced counter transference in clinical teaching. Paterson and Groening (1996:1123) found that when the relationship between the teacher (who could be a clinical facilitator) and the student nurse has broken down, the student nurse opts to remain silent (sulk). It becomes clear that opting to remain silent is a resentment or hostile attitude which could erode learning in clinical field. Schultz and Schultz (1998:390) have noted that resentment or hostility is a long term consequence of stress in the workplace. These kinds of attitude display signs of disliking, which consequently destroy interaction and communication as well as learning as discussed in section 6.2.5.5. According to Gray and Smith (2000:1546), nurses complain that a poor mentor invariably uses them by delegating unwanted jobs to them, which often results in a feeling resentment and hostility towards that person.

#### **6.5.2.2 *Lack of student's personal responsibility***

The experience of a lack of student nurses' personal responsibility was also identified as an erosive factor in clinical learning. The evidence contained in data display 6.4.2.2 seem to be related to, and being influenced by, negative experiences such as being demoralised, frustrated, lingering and being negated as reflected in data display 6.2.3 and discussed in section 6.3.

Lack of student nurses' personal responsibility is reflected in students:

- sitting idly not doing nursing activities
- visiting friends in other wards while being on duty
- regarding allocated activities as strenuous
- taking sick leave
- remaining in the nurses home when supposed to be on duty
- getting out of the clinical environment
- taking extended out or unauthorised lunch breaks

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**DATA DISPLAY: 6.4.2.2**  
**THEME 4: EROSION FACTORS IN CLINICAL LEARNING**  
**CATEGORY 2: STUDENT NURSES' ATTITUDINAL ISSUES**  
**SUB-CATEGORY 2: LACK OF THE STUDENT'S PERSONAL RESPONSIBILITY**

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- ◇ But if I see that I don't have anything to do, at times I just sit down or visit some other wards (Data:49).
  - ◇ I can still remember that there were students who remained in the nurses' home while we went to the clinical field. These students remained sleeping (Data:246).
  - ◇ And when I felt sick, I would go to the nurses home and sleep without anybody realising that I am not in the ward (Data:498).
  - ◇ It is easy for us to go and sleep as we wish because some sisters are not role modelling, when the matron is not there, they go where ever they want, so if I see a sister doing that as a student, I just imitate (Data:500).
  - ◇ At X Hospital because it is near the campus, if it is teatime, students go to the campus, or we go to the shopping complex to buy our things and mind you, we take 2 hours lunch; 1 hour teatime because it is next to the campus (Data:513).
  - ◇ If people are not role modelling I don't feel (gore) that I'm going to work because they are not even in uniform (Data:531).
- 

In Girot's (1993:117) study, communicating happiness seemed to be a recurring feature for all student nurses, where lack of pleasure in the learner's work would influence her practice. If a student lacks pleasure in his or her work it can manifest itself through lack of responsibility. Lack of responsibility can have a wide-ranging and negative impact in learning, for instance, failing and dropping out.

Although a lack of student nurses' responsibility was found in the current study, an indication which displays the quest for a sense of responsibility is shown in Baillie's (1993) phenomenological study regarding factors affecting student nurses' learning in community placements. In Baillie's (1993:1046) study, it was found that one student nurse commented that it is very important for a student nurse to show interest and take initiative in learning within the clinical field. Indeed, society expects nurses to be

autonomous in their thinking and their achievements, to be able to adapt swiftly and creatively to changes in their environments, and to work hard toward self-actualisation (Dumas et al 2000:252). Student nurses can be autonomous in their thinking only when they display a sense of responsibility. Tanner (2002:52) asserts that student nurses need experiences to help them care like nurses. The ability to recognise the value of their experience as a starting point for their professional development allows nurses to remain above the waves of human and technological changes in their day to day professional world but only if they know how to learn (Dumas et al 2000 251). Student nurses will only know how to learn through committing themselves and being accountable and having a sense of responsibility.

Therefore, to understand student nurses' lived world as constituted within the clinical field, it should be viewed from a perspective that will provide for ways to enhance student nurses' personal responsibility and autonomy. This is one area that needs further exploration of find the best ways in which student nurses' sense of responsibility could be increased in the clinical field.

### **6.5.2.3 *Negative perception of trained staff***

The data obtained from the participants during the present study suggest that student nurses have negative perceptions of clinical facilitators. Hamachek (1993:199) defines perception as meanings, which are attached to the information received through our sensory receptors. Quinn (2000:73) elaborates on this definition through stating that in perceptions, an individual selects cues from the environment and draws inferences from these in order to make sense of their experiences. Perception is also a cognitive process by which individuals organise, interpret and understand sensory impressions from their environment (Werner 2003:37). Streubert Speziale and Carpenter (2003) articulate perception with phenomenology. In the articulation Streubert Speziale and Carpenter (2003:56) state that whatever the individual creates or constructs, whether mental or physical, tangible or intangible, it is constructed on the foundation of perception.

The negative perceptions student nurses hold of trained nurses derive from both personal experiences and from having heard things about certain trained nurses.

Student nurses mentioned that trained nurses are harsh, lazy, and selfish and they are not suitable role model material. As one participant put it:

You know, sisters in that hospital are not role modelling, because they don't even wear uniform (Data:516).

Through misperceiving and having misconceptions about trained nurses, student nurses had negative experiences as described in section 6.3.3, which, in turn, predisposed them to the loss of a sense of responsibility (section 6.5.2.2), initiating a downward learning spiral.

Data display 6.4.2.3 exhibits statements on negative perceptions of student nurses of trained staff as:

- using students as working force and overworking students
- being harsh
- being lazy
- not role modelling
- self-fish

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**DATA DISPLAY: 6.4.2.3**

**THEME 4: EROSIIVE FACTORS IN CLINICAL LEARNING**

**CATEGORY 2: STUDENT NURSES' ATTITUDINAL ISSUES**

**SUB-CATEGORY 3: NEGATIVE PERCEPTION OF TRAINED STAFF**

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- ◇ What is being done in the wards, to be honest, I thought that when I go to the wards, the sisters would **make me** a working force (Data:126).
  - ◇ What I heard from other students was that the sisters in the wards are **harsh**, they like giving students a lot of work and patch shortage of their staff in the wards (Data:129).
  - ◇ With other sisters, I could see that even when I go next to them, they don't need a student next to them (Data:320).
  - ◇ Some sisters are too **lazy** they just say "order—order---order" and when I don't understand, they label me as a student to be lazy (Data:479).
  - ◇ It is easy for us to go and sleep as we wish because some sisters are **not role modelling**, when the matron is not there, they go where ever they want, so if I see a sister doing that as a student, I just imitate (Data:500).
  - ◇ If the sister **does not even care** who am I, what I am doing, then what else (how can I learn) can I do as a student (Data:501)?
  - ◇ As a student, I just look at the sister and tell myself inwardly that this sister is **selfish** (Data:530).
- 

According to Gray and Smith (2000), negative perceptions of student nurses about trained nurses appear to be a concern. There is little doubt that some clinical facilitators break promises, lack knowledge and expertise, have poor teaching skills, and have no

structure in their teaching (Gray & Smith 2000:1546). According to these researchers, poor mentors are often distant, less friendly, and unapproachable and intimidate student nurses. Dickerson et al (2000:192) found that the Native American student nurses in the USA perceived the continuous faculty feedback regarding their performance as negative criticism and that constant evaluation was perceived as judgemental and disrespectful. Negative perceptions usually occur in situations where there are no trusting relationships.

Perceptions regarding being used as a workforce display a lack of understanding regarding what student nurses are expected to learn in the clinical field. To prevent negative perceptions, both student nurses and clinical staff should realise that much of what student nurses need to know is hidden in the day-to-day activity of nursing (Edmond 2001:253). In addition to this, good placements for student nurses must be found where positive relationships could be developed. Werner (2003:47) warns that incorrect perceptions and attributes of people can be perceived as being unfair which can harm interpersonal relationships. Consequently the way student nurses perceive the clinical field around them can dramatically influence what they pay attention to and how they behave within the clinical field. Therefore, student nurses should be made aware of, and should concentrate on, learning opportunities so that they may gain optimum clinical learning experiences.

#### **6.5.2.4 Retaliation**

To *retaliate* denotes to strike back, get even, give tit for tat, and to take revenge (Corel WP Thesaurus 1995). Data display 6.4.2.4 outlines statements that show students' retaliation actions. This category also relates to student nurses' perceptions of clinical facilitators. Negative perceptions of clinical facilitators may predispose student nurses to retaliate. Retaliation strategies applied by students involve:

- Ganging up
- Refraining from performing activities
- Not availing themselves in the clinical field

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**DATA DISPLAY: 6.4.2.4**  
**THEME 4: EROSION FACTORS IN CLINICAL LEARNING**  
**CATEGORY 2: STUDENT NURSES' ATTITUDINAL ISSUES**  
**SUB-CATEGORY 4: RETALIATION**

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- ◇ Because of not being shown what we must do, we said tomorrow we should do a sit in (Data:184).
  - ◇ By "sitting in" we meant sitting in the ward, reading our books and discussing, not following any sister who does not want to talk to a student (Data:186).
  - ◇ If people are not role modelling I don't feel (gore) that I'm going to work because they are not even in uniform (Data:531).
  - ◇ Sometimes I just don't work if the sisters are not working just to make them to be aware that what they are doing is completely wrong (Data:533).
- 

Related to the findings of the present study, Gray and Smith (2000:1546) found that student nurses cope with poor mentors by engineering their off duties to reduce the times they work with these individuals. According to Rosenberg et al (2004:50), when an organism is kept in some way from attaining its goals, the resulting frustration leads directly to aggressive behaviour, which is directed to removing the obstacle in order to attain the desired outcome. Strategies such as ganging up; refraining from performing activities; and not availing self in the clinical field as demonstrated by student nurses reflect displaced aggression.

Student nurses should, however, also learn to express and discuss their feelings with the clinical facilitators, rather than diverting their frustrations to devise mechanisms to scare clinical facilitators, in an attempt to avoid erosion of learning in the clinical field.

#### **6.5.2.5 Status of students in the clinical area**

In South Africa, student status refers to the fact that when student nurses are placed in the clinical fields, they should be actively involved in nursing patients as members of the nursing and health team, in order to practise and master their general, psychiatric and community and midwifery skills (SANC 1992). In the UK, the Royal Council of Nursing (RCN 2005:11) states that all students undertaking pre-registration nursing and midwifery programmes have supernumerary status while on practice placements. This means that they are additional to the workforce requirement and staffing figures. The RCN (2005:11) states explicitly in its guidelines that the student nurse is placed in the clinical setting as a learner and not as a member of staff, therefore, they make a

contribution to the work of the practice area only to the extent that it enables them to learn how to care for patients.

Students, when entrusted with an activity or task, should first evaluate whether such an activity or task relates to learning (directly relating to the outcomes set to be attained during clinical exposure) or whether it is merely work; patching up staff numbers. Though this critical evaluation by students is justified, it also indicates conflict, or at least a degree of mistrust, in the clinical field. When routine clinical activities are allocated to student nurses, they see themselves as becoming part work force, or patching up staff shortages. This may also relate to student nurses experiencing a dichotomy between their responsibilities as students and their responsibilities as members of staff, a dilemma of immediate responsibility (to meet patient needs for instance and workload demands) and long-term responsibility towards their academic development. As one student participant said:

It's like they use us students to patch up their staff members, so it is not easy to learn like that (Data:756).

Further evidence relating to “student status” as a negative experience is contained in display 6.4.2.5.

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**DATA DISPLAY: 6.4.2.5**  
**THEME 4: ERODING FACTORS IN CLINICAL LEARNING**  
**CATEGORY 2: STUDENT NURSES' ATTITUDINAL ISSUES**  
**SUB-CATEGORY 5: STATUS OF STUDENT IN THE CLINICAL AREA**

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- ◇ I also felt that that was not regarded as learning, but as working (Data:54).
  - ◇ A working force is someone who comes to work with the aim of working and earn salary at the end of the month rather than learning as a goal (Data:128).
  - ◇ ... They like giving students a lot of work and patch shortage of their staff in the wards (Data:129).
  - ◇ If I am a working force as a student, the learning outcomes are not considered (Data:130).
  - ◇ I also experience a problem in telling between my responsibility as a student and as a member of staff (Data:560).
  - ◇ If there is no staff they say “you are wasting time by doing that do this and this so you won't learn like that” (Data:752).
  - ◇ It's like they use us students to patch up their staff members, so is not easy to learn like that (Data:756).
- 

The findings of the current study seem to be supported by various studies. Student nurses frequently experienced conflict between their roles as members of staff and their role as student nurses (Hart & Rotem 1994:29). In the same vein, student nurses

described themselves as being *students* when studying outside the clinical setting in such activities as reading, preparation of nursing care plans and practising skills in the laboratory, but, assumed the role of a *nurse* when involved in direct patient care (Wilson 1994:85). Streubert (1994:29) indicates that the challenge involved in this relates to assessing the boundaries inherent in the student nurse's role and the way things are taught to them and adjusting to the way things are actually practised in the clinical field.

It could be argued that differences in understanding the status of student nurses in the clinical field could erode learning. Twinn and Davis (1996:180) concurred that data demonstrated confusion, experienced by practitioners, in the interpretation of students' supernumerary status. The confusion was shown because some practitioners interpreted supernumerary status to mean that student nurses were not allowed to participate in care, while others interpreted it as students being restricted to the ward environment to learn the practical side, thereby limiting the learning opportunities available to the student nurses. Similarly, Neill et al (1998:18) mentioned that there appeared to be confusion among sophomore student nurses about their roles and what was expected of them in the clinical field.

In order to avoid confusion regarding the understanding of student nurses' status, Little (2000:393) suggests that focus can be achieved by formalising the student nurse's status through recognising the distinction between the student nurse and the staff nurse, and by protecting some degree of supernumerary status of the student nurse. Student nurses' status legitimises their involvement in learning activities which is a priority over day-by-day responsibilities (Little 2000:394).

As outlined by the RCN (RCN 2005:11), mentors (clinical facilitators) are expected to be aware of the following regarding *supernumerary* status that:

- all student nurses have supernumerary status
- all student nurses' experiences should be educationally led
- they are accountable for any decision to delegate work to student nurses and for that work being undertaken
- student nurses should be allowed to experience a range of relevant educational activities during the placement

- student nurses' contribution to care should be commensurate with their level of training
- student nurses should adhere to the shift patterns of the placement and should attempt to work as many shifts with their mentor as possible
- the supernumerary status of the student should be respected by all members of staff in the placement

### 6.5.3 Student perceptions of clinical facilitators

Student nurses' perceptions of clinical facilitators' attitudes in general, could be detrimental to learning in the clinical environment. Students' perceptions are that clinical facilitators are: negative role models, self-centred, and focussed on mistakes made by students. Data display 6.4.3 gives an overview of the different sub-categories in this regard.

<b>DATA DISPLAY 6.4.3</b>	
<b>THEME 4: EROSION FACTORS IN CLINICAL LEARNING</b>	
<b>CATEGORY 1: STUDENTS' PERCEPTION OF CLINICAL FACILITATORS</b>	
<b>OVERVIEW</b>	
◇	Being a negative model (Data display: 6.4.3.1)
◇	Self-centeredness (Data display: 6.4.3.2)
◇	Reflecting upon mistakes (Data display: 6.4.3.3)

#### 6.5.3.1 *Being a negative model*

“Model” refers to someone who exemplifies ideal behaviour to the student nurse (Reilly & Oermann 1992 330), and as discussed in section 6.2.4.7, the current study refers to a *negative* model as a person who exhibits undesired behaviour.

Data display 6.4.3.1 exhibits evidence relating to negative modelling by clinical facilitators. Participants indicated that negative modelling becomes apparent in the clinical field, when clinical facilitators “disappear” in the absence of the nurse manager and when they do not wear full uniform. Lack of role modelling erodes learning; as one participant said:

If people are not role modelling I don't feel (gore) that I'm going to work because they are not even in uniform (Data:531).

This category also relates to category 6.1.3, on student nurses' expectations with regard to the conduct of clinical facilitators. As indicated in section 6.2.3.6, student nurses expect facilitators to model certain desired behaviours in the clinical field. If such behaviours are not modelled, facilitators appear inauthentic to students.

Subcategory 6.4.3.1 displays further evidence relating to students' perception of facilitators as negative role models.

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**DATA DISPLAY: 6.4.3.1**  
**THEME 4: EROSION FACTORS IN CLINICAL LEARNING**  
**CATEGORY 3: STUDENTS' PERCEPTION OF CLINICAL FACILITATORS**  
**SUB-CATEGORY 1: BEING A NEGATIVE ROLE MODEL**

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- ◇ Some sisters are not role modelling, when the matron is not there, they go where ever they want, so if I see a sister doing that as a student, I just imitate (Data:500).
  - ◇ You know, sisters in that hospital are not role modelling, because they don't even wear uniform (Data:516).
  - ◇ Remember, as a first year student, one is from high school, and if I find people in clinical field behaving in a specific fashion, I just copy that, and comfort zones are more comfortable to us as students (Data:518).
  - ◇ If people are not role modelling I don't feel (gore) that I'm going to work (Data:531).
- 

Linking up with the evidence in data display 6.4.3.1, Kosowski (1995:238) found that student nurses remembered observing clinical facilitators, such as staff nurses, physicians, and ancillary health care workers, interact with patients in ways that were unprofessional, and 'non caring' or 'uncaring'. According to Attridge (1996:409), many student nurses perceived faculty enthusiasm surrounding nursing as reflecting bias, perceived by students to be in conflict with the real world of nursing practice. This caused student nurses to doubt the authenticity nursing; something they were expected to learn to appreciate. In essence, these dualistic perceived and received versions of nursing are experienced by students as poor role modelling. Twinn and Davis (1996:183) also demonstrate that student nurses spent a considerable amount of time providing unsupervised patient care. Such un-supervised actions are also perceived as poor or negative modelling.

The present research findings concur with finding of a previous study by Mongwe (2001). For instance, during participant observation, negative role modelling such as reporting late for work and making negative comments about patients were observed (Mongwe 2001:120). In more recent literature, Carlson et al (2003:35) found that

student nurses verbalised that they were not getting opportunities to practice skills with each other because staff would say they are taking too long. Informing student nurses that they are taking too long confirms negative modelling because in cases where procedures should be practised systematically, students could take longer to do so. Du Plessis (2004:76) reported that student nurses experienced that their tutors (as facilitators) were not seen as role models and they felt cheated because of an apparent lack of preparation for sessions or the lack of skills in particular procedures on the part of these facilitators.

### **6.5.3.2 Self-centredness**

Self-centredness represents the inability to see events from others' points of view (Louw & Edward 1998:490). Data display 6.4.3.2 demonstrates that student nurses' perceived self-centredness of clinical facilitators to be an erosive factor to learning in the clinical field.

Perceived self-centredness on the part of the clinical facilitator was reflected through facilitators':

- threatening of student nurses
- arrogance about their distinguishing devices
- restricting student nurses from participating in doctors' rounds
- making students to feel unworthy

A statement that manifests clinical facilitators' self-centredness reads:

Other things were that: "you will fail like the other uncooperative students if you continue with the behaviour." She (facilitator) will leave us like that (Data:195).

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**DATA DISPLAY: 6.4.3.2**  
**THEME 4: EROSION FACTORS IN CLINICAL LEARNING**  
**CATEGORY 3: STUDENTS' PERCEPTIONS OF CLINICAL FACILITATORS**  
**SUB-CATEGORY 3: SELF-CENTREDNESS OF CLINICAL FACILITATORS**

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- ◇ Sister in charge warned us, she said that if we repeat (sitting and read books in the ward and not working) again she will take the matter to the campus, and that we do not want to work and we are earning government salary (Data:192).
  - ◇ The sister in-charge said so many things that made me feel so unworthy of any kind of learning (Data:193).
  - ◇ ... .they just look at their (epaulets) and say, "we can't force you to learn because we already have our epaulets"(Data:527).
  - ◇ Say like--- I think they take it personally---"you students you want doctors" but I find that I want to learn, and sometimes they take it the other way round. Sometimes I get this warning when I get to the ward (High tone) "don't go next to a doctor" just like that you see, (laugh)---mmm---just like that, so when I am told to do that, when the doctor comes I just be very far (Data:667).
- 

The findings of the current study are congruent with those of other researchers, in particular with those of Baillie (1993:1048), Twinn and Davis (1996:181), Dickerson et al (2000:193), Gray and Smith (2000:1546) as well as Carlson et al (2003:36).

Baillie (1993:1048) found that, not all clinical staff seemed interested or positive towards having student nurses within the clinical field. Student nurses did not find this attitude helpful to their learning. In the study conducted by Twinn and Davis (1996:181) one professional nurse argued that it would be "unfair" of her to work with student nurses as they are nervous. Viewing assisting student nurses as unfair could display signs of egocentricity. In the study conducted by Gray and Smith (2000:1546) regarding the qualities of an effective mentor, student nurses also noted that poor mentors are often distant, less friendly, unapproachable and that they intimidate student nurses. In the same vein, Carlson et al (2003:36) indicate that student nurses verbalised that professional staff laugh at them without providing guidance.

It is expected that clinical facilitators should transform the clinical field into a conducive learning environment in which student nurses would want to learn. Self-centredness on the part of clinical facilitators might erode all attempts in this direction.

### **6.5.3.3 *Pre-occupation with students' mistakes***

Students found clinical facilitators to be pre-occupied with the mistakes they made; even when students approach them for assistance and clarification, the error being made is amplified making students feel inferior and inapt.

Two main sub-categories compile this category namely:

- Pre-occupation with students' mistakes
- Labelling student nurses

Arguing often results in the clinical setting between student nurses and clinical staff. Often such arguments seem to stem from facilitators' reactions to reasonable requests made by students. It was pointed out during interviews that whenever student nurses requested to be assisted to understand clinical procedures; clinical facilitators indicated that they were not in a position to assist arguing student nurses. An example of such an example includes:

She (facilitator) said that I must know that bed bath falls under my scope of practice as a first year student, when I try to answer, she then said that I must not argue with her (Data:692).

Student nurses were also being labelled as lazy, non-cooperative, arguing, and disrespectful. As a result, student nurses either adopt cooperative acts in trying to cope with the situation or disappear or distance themselves from the clinical facilitator, or they do not perform any activity in the unit resulting in erosion of their learning. Data display 6.4.3.3 exhibits statements on facilitators' preoccupation with student nurses' mistakes, as an erosive factor to clinical learning.

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**DATA DISPLAY: 6.4.3.3**  
**THEME 4: EROSION FACTORS IN CLINICAL LEARNING**  
**CATEGORY 3: STUDENTS' PERCEPTIONS OF CLINICAL FACILITATORS**  
**SUB-CATEGORY 4: PREOCCUPATION WITH STUDENTS' MISTAKES**

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**Reflecting upon mistakes (6.4.3.3.1)**

- ◇ Last year 2003 we use to strike in hospital X, so when we went to the clinical field, they didn't want to teach striking stubborn students (Data:428).
- ◇ They said that because we students were striking, when the tutors want to teach us something, we started striking, now we are asking about a procedure which they wanted to teach us when we started striking (Data:429).
- ◇ Those sisters were not good ones, when a child do something wrong you don't forget that thing that the child do, everything you just refer back the mistake (Data:434).
- ◇ We felt very bad when they refer to our mistakes (Data:435).
- ◇ Most of the times they (clinical facilitators) will say, "you could have finished the syllabus, but you were striking" (Data:438).

**Labelling student nurses (6.4.3.3.2)**

- ◇ Some sisters are too lazy they just say "order—order---order" and when I don't understand, they label me as a student to be lazy (Data:479).
- ◇ I think maybe sometimes they might take it personally, like I'm arguing with sisters in the ward, I'm rude, arguing and I'm not respecting (Data:673).

**Threatening behaviour on the part of the facilitator (6.4.3.3.3)**

- ◇ To be honest, if they send me at 8h00 after cleaning in the morning, I just took what the sister had given me and send because if I had refused they were not going to sign my workbook, saying that I am not cooperative because I don't want to do this or that (Data:485).
- 

Being preoccupied with students' mistakes in some of the statements contained in the data display, borders on intimidation. According to Gray and Smith (2000:1546), it was also noted that poor mentors are unapproachable and intimidate student nurses. If student nurses in the clinical field experience intimidation, either due to reflecting upon their mistakes or by other factors, learning in the clinical field could be eroded.

With regard to "labelling nurses," Dickerson et al (2000:193) revealed that the native American student nurses experienced that speaking up for oneself had its own set of negative outcomes. It appeared to student nurses that faculty communicated with each other about student nurses who spoke up about problems, either in class or in the clinical field.

According to labelling theory as pointed out by Rosenberg *et al* (2004:23), individuals are not considered deviant merely because they break social rules; they must be labelled deviant according to previously existing social expectations. Individuals labelled in a certain fashion begin to behave in the ways people expect them to act.

Preoccupation with student nurses' mistakes could also be associated with self-centredness (section 6.5.3.2) and being a negative model (section 6.5.3.1) which also contribute to student nurses' attitudinal issues (section 6.5.2). All of these could erode learning in the clinical field.

#### **6.5.4 Erosive elements in the environment**

"Environment" denotes surroundings, conditions, atmosphere, climate and circumstances (*Readers' Digest Oxford Dictionary* 1993:494). The part that the environment plays in the learning of student nurses in the clinical field could be viewed in terms of whether it is conducive or non-conducive to student learning. Erosive elements as experienced by student nurses in the clinical field include non-conducive physical and psychosocial environment, as well as inconsistency in the accompaniment by facilitators.

Data display 6.4.4 gives an overview of the sub-categories which compile this category within theme 4: Erosive factors in clinical learning.

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<b>DATA DISPLAY 6.4.4</b>
<b>THEME 4: EROSIIVE FACTORS IN CLINICAL LEARNING</b>
<b>CATEGORY 4: EROSIIVE ELEMENTS IN THE ENVIRONMENT</b>
<b>OVERVIEW</b>
<hr/>
◇ Non-conducive physical environment (Data display: 6.4.4.1)
◇ Non-conducive psycho-social environment (Data display:6.4.4.2)
◇ Inconsistency in accompaniment of student nurses (Data display: 6.4.4.3)
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##### **6.5.4.1 Non-conducive physical environment**

A non-conducive physical environment has a detrimental impact on student nurses' learning and development in the clinical field. For instance, data display 6.4.4.1 exhibits statements on a non-conducive physical environment, which was experienced as being erosive by students in the clinical field.

Student nurses who participated in the study revealed that some nurses' homes do not have basic domestic and home entertaining appliances such as television, kitchens, sitting rooms or radios. Boredom and a general feeling of desolation resulted from this.

An example of a non-conductive physical environment pointed out by one student nurse during an interview reads:

It is not nice to collect a drinking water from the toilet, even if I know that the water is not from the toilet but that smell in the toilet is terrible (Data:540).

Erosive factors in relation to general environment of the hospital also came to light. An example of the hospital physical environment included old buildings and not well maintained infrastructure characterised by leaking taps, as well as blocked toilets. For students staying in the nurses' home, their total physical environment thus becomes a depressing one. As the nurses' home is associated with the hospital and the hospital with the nurses' home, the total environment becomes erosive to learning. As emphasised by humanistic existentialists and phenomenologists, including Heidegger (1962 cited in Becker 1992:13) as well as Rice and Ezzy (1999:16), a person is always *in* the world; to exist is to exist "somewhere." This "somewhere" has definite implications for the students in terms of the existential baseline of the present study. Data display 6.4.4.1 contains statements relating to the non-conductive physical environment.

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#### DATA DISPLAY: 6.4.4.1

#### THEME 4: EROSIIVE FACTORS IN CLINICAL LEARNING CATEGORY4: EROSIIVE ELEMENTS IN THE ENVIRONMENT SUB-CATEGORY 1: NON CONDUCTIVE PHYSICAL ENVIRONMENT

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##### The nurses' home environment (6.4.4.1.1)

- ◇ The nurses' home does not have TV, where a person can refresh her mind, relax and relieve all day stress from the ward routine, patient's conditions and the complaints from patients and relatives (Data:90).
- ◇ It is so boring in the nurses' home because there is no TV or radio to refresh my mind, or a launch room where one can refresh her mind with her colleagues after hours (Data:93).
- ◇ 21h00 I went to the nurses' home, I remember sleeping in the single bed with a very old table burnt on the side, (Data:94).
- ◇ What we experience in the nurses home also affect our learning negatively (Data:536).
- ◇ In the nurses home we spend most of our time there, there is no study rooms for students to study, the beds are not comfortable the lockers are very old (Data:537).
- ◇ if one can have privacy, comfortable study desks and beds it will be better(Data:539).
- ◇ Because some nurses homes doesn't have a kitchen. If I am from work and I don't relax I wake up being very exhausted, as a result my learning will be affected (Data:541).

##### Hospital environment (6.4.4.1.2)

- ◇ In other hospitals, buildings were very old, in this old hospital environment haa ..., the taps were not working toilets blocked, ah, in the ward I found that their taps were not working, they use to block (Data:355).
  - ◇ Aah, many things, many things, that hospital was very dilapidated (Data:356).
  - ◇ This enabled me not to capture what ever learning experience available in those units, that environment was not conducive to learning (Data:359).
-

According to the SANC, and nurses' rights, to enable the nurse to provide safe, adequate nursing, they have the right to a safe working environment which is compatible with efficient patient care and which is equipped with at least the minimum physical, material and personnel requirements. SANC's position is supported by the College and Association of Registered Nurses of Alberta in Canada (CARNA 2006), as they state that nurses value and advocate for quality practice environments that have the organisational structures and resources necessary to ensure safety, support and respect for all persons including student nurses in the work setting.

Nurses must advocate for work environments in which nurses and other health workers are treated with respect and are supported when they raise questions or intervene to address unsafe or incompetent practice. Nurse managers/administrators must strive to provide adequate staff to meet the requirements of quality nursing care as part of their fundamental responsibility to promote practice environments where fitness to practise and safe care can be maintained (CARNA 2001).

As part of a moral community, nurses acknowledge their responsibility in contributing to quality practice settings that are positive, healthy work environments. Nurses should collaborate with nursing colleagues and other members of the health team to advocate for health care environments conducive to ethical practice and to the health and well-being of clients and others in the setting. They do this in ways that are consistent with their professional role and responsibilities (CARNA 2006). It must be remembered that elements of physical environment are closely related to the psychosocial environment and the social positions and roles of individuals (Orem 2001:59).

An environment conducive to learning has much in common with an environment conducive to convalescence and recuperation. Such learning environments should have adequate space, lighting, low noise levels, should be generally aesthetically pleasing, and should have all required equipment. Ulrich and Zimring (2004:26) found more than 600 rigorous studies linking a range of aspects relating the structural environment of hospitals to staff stress and effectiveness. It can be assumed that these factors would also influence learning in the clinical setting.

### **6.5.4.2 Non-conductive psycho-social environment**

A psycho-social environment refers to the environment involving the influence of social factors or human interactive behaviour (*Readers' Digest Oxford Dictionary* 1993:1232). Some aspects of a psychosocially conducive learning environment include comfort and orderliness of facilities, peer norms that are prevalent, administrative staff-student cohesion and support systems, and the extramural sharing of activities between staff and students. Such activities help student nurses and clinical facilitators to appreciate each other better and to share some of the same goals. This way, the psychosocial environment is strengthened (Sackney 2006). Boyd et al (1998:104) summarise Kolb's (1980) four basic characteristics of a *learning* environment namely: respect for individual personalities, freedom of expression and availability of information, participation in decision-making, and mutual responsibility in planning, setting goals and evaluating. The discerning reader will note that much of what has been said on the erosion of learning in the clinical setting, outside of this category on the "non-conductive psychosocial environment" could erode the basic attributes of an environment conducive to learning as summarised by Kolb (1980 cited in Boyd et al 1998:104).

Data display 6.4.4.2 contains data on non-conductive psycho-social environmental aspects as experienced by student nurses who participated in the current study.

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**DATA DISPLAY: 6.4.4.2**  
**THEME 4: EROSIIVE FACTORS IN CLINICAL LEARNING**  
**CATEGORY4: EROSIIVE ELEMENTS IN THE ENVIRONMENT**  
**SUB-CATEGORY 3: NON-CONDUCTIVE PSYHO-SOCIAL ENVIRONMENT**

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- ◇ The nurses' home does not have TV, where a person can refresh her mind, relax and relieve all day stress from the ward routine, patient's conditions and the complaints from patients and relatives (Data:90).
  - ◇ It is so boring in the nurses' home because there is no TV or radio to refresh my mind, or a launch room where one can refresh her mind with her colleagues after hours (Data:93).
  - ◇ 21h00 I went to the nurses' home, I remember sleeping in the single bed with a very old table burnt on the side, (Data:94).
  - ◇ What we experience in the nurses home also affect our learning negatively (Data:536).
  - ◇ Because some nurses homes doesn't have a kitchen. If I am from work and I don't relax I wake up being very exhausted, as a result my learning will be affected (Data:541).
  - ◇ This enabled me not to capture what ever learning experience available in those units, that environment was not conducive to learning (359).
-

From the contents of data display 6.4.4.2 it is conceivable that when an environment appears not to comply with the psycho-social needs of a student nurse it can cause the student nurse to feel demoralised (section 6.3.3.2), anxious and worried. The researcher could, however, not find specific studies on the hospital setting as learning environment from a psychosocial educational perspective. This is also supported by Chan (2002:71).

#### **6.5.4.3 *Inconsistency in accompaniment of student nurses***

Inconsistency refers to “variation, difference, and dissimilarity” (*Corel WP Thesaurus* 1995); while accompaniment emerged from the word *accompany*. To accompany is to attend, go or come along with, keep a person company (occupied), guide, linked with or be part of (*Readers’ Digest Oxford Dictionary* 1993:11). Therefore inconsistency in accompaniment refers to differences, or dissimilarities, in going along or keeping student nurses company and guided in the clinical field.

According to the philosophy and policy of the South African Nursing Council, in the clinical practice area, all registered nurses or midwives are obliged to accompany student nurses (SANC 1992b:5). In addition to the above issue, the SANC (1992) states clearly in its guidelines that all nursing science subjects with practical components *are* presented with accompaniment, over the whole duration of the course.

Inconsistency in the accompaniment of student nurses are suggested by data contained in data display 6.4.4.3. In this data display, it is mentioned that finding a clinical tutor in the clinical field or being able to go along with a clinical tutor from the college campus to the clinical field is something that does not often happen. Coming across a clinical tutor who provides guidance to student nurses during clinical placement vary from one institution to another. According to student nurses’ experiences, for instances, in some institutions the clinical tutor was available, while in other institutions the clinical tutor was not available to students. A one student nurse verbalised:

... I finish the whole practical without seeing the clinical tutor, she is based in the nursing school, she has other work to do (Data:712).

Other experiences, in this regard, are exhibited in data display 6.4.4.3.

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**DATA DISPLAY: 6.4.4.3**  
**THEME 4: EROSION FACTORS IN CLINICAL LEARNING**  
**CATEGORY 4: EROSION ELEMENTS IN THE ENVIRONMENT**  
**SUB-CATEGORY 2: INCONSISTENCY IN STUDENT NURSES' ACCOMPANIMENT**

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- ◇ ... we **go alone** and I find the clinical tutor nowhere (Data:712)
  - ◇ I **finish the whole practical without seeing the clinical** tutor, she is based in the nursing school, she has other work to do (Data:712).
  - ◇ They (tutors) **do come, but not too often**, I remember I stayed at the clinic the whole month, the clinical tutor never came there, but the other tutor came once from the campus, during that whole month (Data:722).
- 

The most central impression gathered from the data contained in this category regarding inconsistency in accompaniment of student nurses is that there is no standard set regarding accompaniment by, or placement of, clinical tutors within the clinical field.

In the study conducted by Attridge (1996:408) it was found that in one hospital student nurses tended to visit families alone without direct faculty supervision and saw little of any nursing personnel although faculty observed and worked closely with student nurses through the vehicle of student nurses' field notes; while in the second hospital, student nurses were supervised closely by faculty and saw many nurses practising their profession in many different ways. Similarly, in the study conducted by Gray and Smith (2000:1545), student nurses viewed having a good mentor and good placement to be associated with luck. This clearly reveals that there were situations when the student nurse was unlucky and not being able to find the clinical tutor. Speaking about inconsistency in accompaniment of student nurses, Du Plessis (2004:76) indicates aspects experienced by student nurses such as a wide range of negative emotions primarily related to programme scheduling and timing.

It is critically important to note that standardised methods of accompaniment of student nurses should place more emphasis on the progress of student nurses, which would promote learning rather than erode learning.

### **6.5.5 Summary**

With regard to student nurses' experiences of factors erosive to learning in the clinical field, both environmental and human factors play a role. These relate to:

- assignment of responsibilities
- student nurses' attitudes

- clinical facilitators' attitudes
- environmental factors

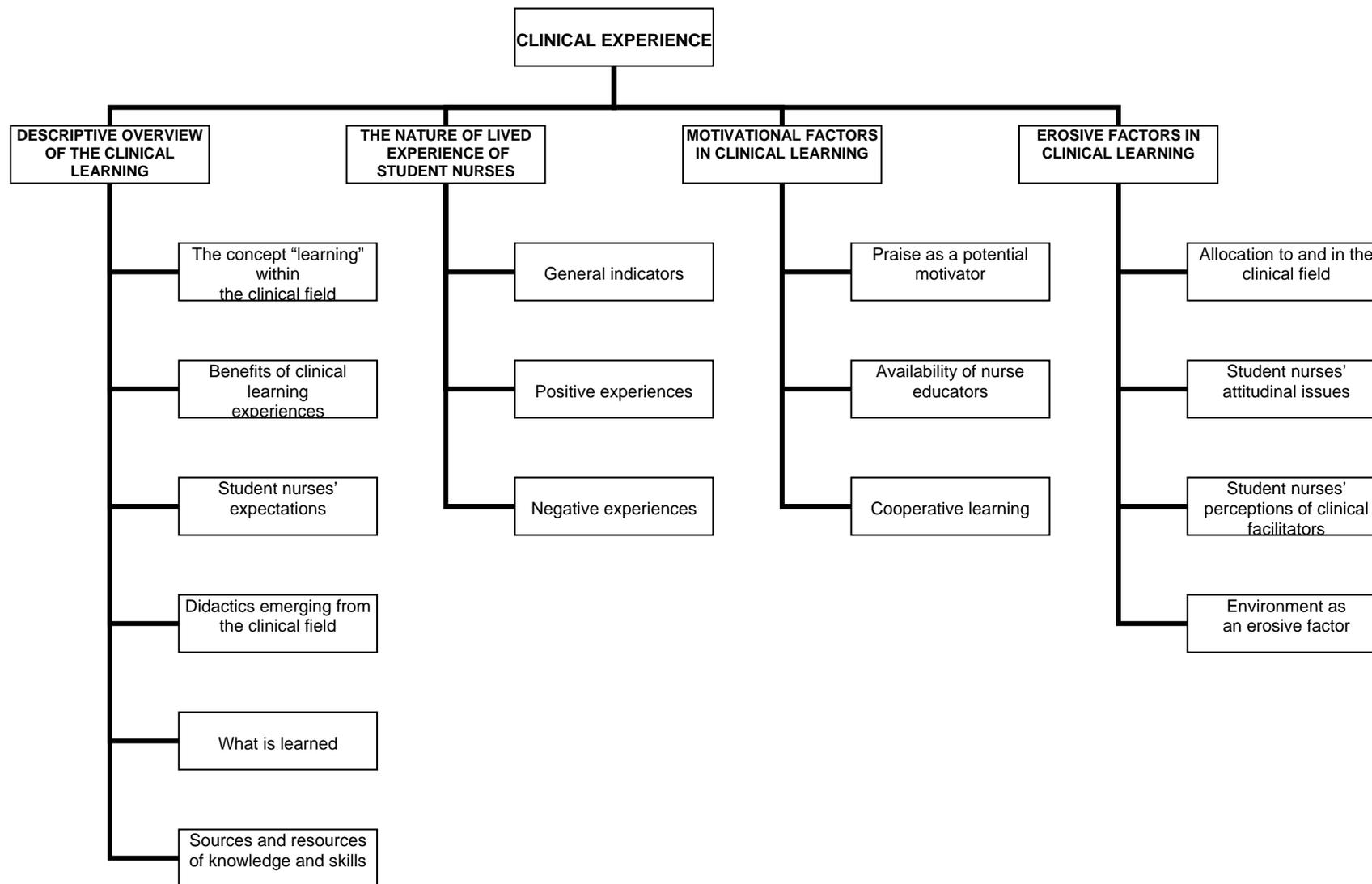
## **6.6 CONCLUSION**

In this chapter, a presentation of data, themes and categories with specific literature support was done. The findings of this study expand and deepen the understanding of learning within the clinical field. The deeper understanding include:

- A descriptive overview of clinical learning
- The experiences of student nurses within the clinical field
- Motivational factors in clinical learning
- Erosive factors within the clinical field

These four themes with relating categories and sub categories are summarised and presented visually in figure 6.1. In the next chapter these themes and categories are related to specific existing theories to complete the theory development perspective of qualitative research proper.





**FIGURE 6.1**  
**AN OVERVIEW SUMMARY OF MAJOR THEMES, CATEGORIES**



## Chapter 7

### Relating emergent construct to existing theory

#### 7.1 INTRODUCTION

According to Wertz (1984:44), “the validity of psychological formulations of all types and levels rest on the precision and comprehensivity with which it refers to the immanent structure that essentially constitute the phenomenon under study. This structure must be internally cohesive and must include all constituents of the phenomenon expressed implicitly and explicitly in the descriptive data base.” In this chapter, the researcher arrives at such a “structure” that accommodates all aspects (constituents) of the phenomenon expressed implicitly and explicitly in the descriptive data base, as explicated in chapter six.

In adhering to Wertz’s viewpoint, in this chapter, the researcher returns to the data presented in chapter 6 with the questions: “What accounts for most aspects, if not every aspect, contained in the data?” and “What is the core, the underlying essence, involved?” After careful deliberation and contemplation involving all the different categories as explicated in chapter six, the researcher arrived at the conclusion, or rather the conviction, that the single most fundamental and all encompassing category, that category that accommodates all other categories and without which none of the categories would make sense is “**awareness.**” In this also see section 6.3.2.3.

In addition to briefly discussing *awareness* from different perspectives and disciplines in this chapter, awareness is also articulated on existing theory in nursing and education. “Awareness” thus serves as a pivotal point and area of interface, a passage and central concept through which, and by which, theory in support of the research findings can be identified and the findings further explicated. In addition, it is on this central concept of “awareness” that the researcher based recommendations and suggested interventions in clinical education.

The concept “awareness,” as will be indicated in the rest of this chapter, is foundational in phenomenology and consequently also in existential and humanistic thinking.

Theoretical constructs discussed are thus accommodative of “awareness” both because of the philosophical base of these theoretical constructs and/or because of the implicit or explicit position the concept “awareness” takes in some of these constructs.

In this chapter, the researcher in essence adheres to the theory generating and theory development aims of qualitative research by relating the outcomes of the present research to existing theory. Through this process aspects of the trustworthiness of the research are revisited as the potential “transferability” of the findings is implied. In addition, the way is paved for future *theory derivation* and *synthesis* as explicated by, amongst others (Walker & Avant 1995).

## 7.2 AWARENESS

*I am in my world, I live here, I belong here, I exist here.  
When I speak, I interact with others, I see, I feel, I hear and  
I wonder about things.  
(Van Manen 1991:139).*

### 7.2.1 Presence awareness

As an introductory orientation for the reader, the researcher states her basic understanding of *awareness* as it applies to the research at this point. In this regard, the researcher borrowed terminology from the field of computer and network science namely the concept of “presence awareness.” As Sandelowski (2002:65) indicates, “Media designers and nurses share a common interest in presence: in how to create it, how to use it effectively, and how it works to generate its effects.” With regard to users of the Internet, both online and off-line, the fundamental question is: Where are you now? ([www.masternewmedia.org/news/2004/09/23/presence\\_awareness\\_indicators\\_where.htm](http://www.masternewmedia.org/news/2004/09/23/presence_awareness_indicators_where.htm) - 69k (accessed 2006-08-07). This is a question as to where one finds oneself on the Internet, in cyber space, and among others using the Internet. Essentially, the researcher’s understanding of *awareness* relates to students’ grasp and conceptualisation of: “Where am I?” at any point in time within the clinical setting. This question implies more specific questions such as:

- “Where am I with regard to the attainment of the outcomes set for this specific clinical area?”

- “Where am I heading towards?”
- What is my present position and status among others in the clinical field?
- What am I doing here at this moment in time?

The variations on the question are legion and could be asked with regard to all categories as indicated in table 7.1.

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**TABLE 7.1: AWARENESS QUESTIONS PERTAINING TO MAJOR CATEGORIES AND THEMES**

- How do I perceive learning in the clinical situation? (Category series 6.1.1)
  - What do I really benefit from my clinical experience? (Category series 6.1.2)
  - What are my expectations pertaining to clinical allocation and experience? (Category series 6.1.3)
  - What do I learn from and in the clinical area? (Category series 6.1.5)
  - What sources for learning exist within the clinical area? (category series 6.1.6)
  - What are my positive experiences resulting from my clinical involvement? (Category series 6.2.2)
  - What are my negative experiences resulting from my clinical involvement? Category series 6.2.3)
  - What motivates my learning in the clinical area? (Category series in Theme 3)
  - What erodes my learning in the clinical area? (Category series in Theme 4)
- 

Asking these questions and answering them are important, not only for the student but also for the clinical tutor and staff involved in clinical teaching as presences awareness in the clinical setting, to be successfully maintained as a steering mechanism, involves both the tutor and the student. These questions also address Christiansen and Maglaughlin’s (2003:1130) four major types of awareness namely: workplace awareness, availability awareness, group awareness and contextual awareness.

## **7.2.2 Philosophical stance**

Awareness has a long philosophical history relating to the central arguments in most western philosophy regarding the subject-object relationship. The researcher’s philosophical understanding of the concept “awareness” stems from her introduction to this fascinating field of human endeavour via her readings on phenomenology as explicated in chapter 2. In addition, the fact that “awareness” as an “ontologically

central” concept emerged from the data and that awareness constitutes the central all-encompassing and accommodating concept as it emerged from the data, is most exciting. This concept is also central to the methodology and the meta-theoretical construct underlying the present research namely Phenomenology. In this regard the contents of table 2.2 on Concepts for a Phenomenological View of Life (Becker 1992:21, Streubert & Carpenter 1999:330; Streubert Speziale & Carpenter 2003:56; Vandenberg 1997,) are paraphrased and applied at this point.

“Awareness” results from our embodiment. **Embodiment** as a Phenomenological tenet asserts that through consciousness, one is aware of *being-in-the-world* and it is through one’s body that one gains access to the world. One feels, thinks, taste, touches, hears and is conscious through the opportunities the body offers. At any point in time, and for each individual, a particular perspective and/or consciousness (awareness) exists, which is based on the individual’s history, knowledge of the world, and openness to the world (Munhall 1989 cited in Streubert Speziale & Carpenter 2003:56). This awareness implies **intentionality**; that consciousness (awareness) is always consciousness (awareness) of something, or, the human being is always intending a world, implying that he or she is a being in the world (Vandenberg 1997:204). This is also true of the student nurse, of her embodied presence in the clinical situation. Embodiment and intentionality allows for **being-in-the-world** asserting that whatever the individual creates or constructs, whether mental or physical, tangible or intangible, these are constructed on the foundation of perception, or original awareness of some phenomena (Merleau-Ponti 1956 as cited in Streubert & Carpenter 1999:330). The individual, however, defines part of the self in terms of others. **Being-in-the-world-with-others** at this point becomes important. Any experience of oneself or of another person occurs within such an interpersonal framework (Becker 1992:14). Our **being-in-the-world**, and **being-in-the-world-with-others** represents a state of **thrownness**, experiencing self as ‘thrown into’ a given world. Cultures are well established at the point at which any individual enters life. As the individual grows up he or she becomes an active member in a life formed by factors outside his/her control (Becker 1992:21). This is also true of students in the clinical environment. Awareness or **thrownness** ignites a will towards understanding through *embodiment*, *reflection* and *receptivity*, all the result of awareness, intentionality and being-in-the-world. Through the **reflective** potential the individual is aware of himself/herself (self-awareness) and the world. He or she is also aware of his/her awareness. The individual is thus self-reflective (Becker 1992:14).

This, in terms of the researcher's present understanding of awareness, is the most fundamental awareness and relates to the phenomenological concept of **perceptivity**. What is known, perceived, or believed is influenced by the standpoint of the knower, perceiver, or believer. The way in which one approaches the world both opens up and limits what one finds there. All knowledge is perspectival (dependent on a specific perspective). We can deepen our insights into life by dwelling within a particular perspective. We can also enrich our understanding of life by accessing many vantage points (Becker 1992:23). Ultimately our *awareness* is influenced hereby. In a sense the researcher is doing exactly this in the following section, enhancing *awareness* from the vantage point of different theoretical constructs.

### 7.2.3 Psycho-social vantage point

Gardner (cited in Wells-Federman 1998:115) sees *presence* as a physical 'being there' and a psychological 'being with' the patient for the purpose of meeting the patient's health care needs." To be present in this way in any situation (including presence in the clinical area and presence of the student nurse) one must be present to oneself first (Wells-Federman 1998:115). This is corroborated by Goleman (1998:108) stating: "Presence begins with self-awareness." Being physically and psychologically present means that one completely experiences the moment (moment-to-moment) without being distracted, rushed or fragmented (Goleman 1998:108). *Mindfulness* plays a key role in presence and awareness. Such is the relationship between presence and mindfulness that Wells-Federman (1998:116) equates presence to mindfulness. Likewise, awareness at this point implies mindfulness.

Gardner's point of view is corroborated by McKivergin and Daubinmire (1994:65-81 cited in Watson 1999:225). However, the latter two authors also identify a third level of presence namely *therapeutic presence*. According to these authors, physical presence; "being there" for the other, implies bodily presence and even physical contact. Psychological as "being with the other" involves mind-to-mind connection (Watson 1999:226); having a conscious intention of availing oneself in and to a situation and others, including communication skills such as listening, congruence, unconditional regard and non-judgmental acceptance. **Therapeutic presence** is most closely aligned to consciousness, mindfulness, intentionality and the transpersonal (Watson 1999:226) thus with awareness. The art of nursing, that which students supposedly are exposed to

in the clinical field, contains many of the elements necessary for the cultivation of transpersonal presence and awareness in caring (Watson 1999:231) including: feelings, receptivity, subjectivity/inter-subjectivity, nurturing, cooperation, intuiting and relatedness.

According to Goleman (1998:108), the opposite of psychological presence is *psychological absence*, going through work routines by rote, obviously bored or otherwise disconnected reflecting apathy and anxiety. In a sense, going about one's work in this manner, one may just as well be absent. This is exactly what students did according to the data. If not absenting themselves from work their *lingering* presence did not do much in the way of learning and awareness. The only counter measure seems that: "When fully present, we are more attuned (*aware*. My insertion) to those around us and to the needs of the situation and we fluidly adapt to what is needed – in other words we are in flow" (Goleman 1998:109). Throughout the research the researcher experienced this, notwithstanding students' negative attitudes and experiences, as a state of hopeful expectation on the part of students.

#### **7.2.4 Awareness and presence in caring**

With caring being held a central concept and praxis in nursing, *caring* features in a number of nursing theories and models, both implicitly and explicitly. The researcher first turned her attention to "awareness" in caring per se as identified by Covington (2005:170) and afterwards to nursing theories in general.

Covington (2005:170), in an analysis of the concept of "caring presence" summarised the essence of such presence and consequently of awareness as exhibited in table 7.1.

**TABLE 7.2: SUMMATIVE TRANSLATION OF THE EXTANT THEORETICAL CONCEPT OF PRESENCE IN CARING INTO PRESENCE OF THE STUDENT NURSE IN CLINICAL LEARNING**

<b>AUTHOR</b>	<b>CONCEPT OF PRESENCE ADAPTED TO THE STUDENT SITUATION</b>
Paterson and Zderad (1978)	Reciprocal relationship of availability, openness, mutuality and intimacy
Watson (1979)	Conscious awareness relationship resulting in connection
Roach (1987)	Quality of compassion that allows for sharing
Pettigrew (1990)	Availability of self giving, listening with tangible awareness and becoming willingly involved
Horner (1991)	Full awareness, receptivity and attention
Ray (1991)	Engaging and interaction
Swanson-Kauffman (1991)	Sharing in meanings, feelings and experiences
Gilje (1993)	Inter-subjective and intra-subjective exchange of energy that transform into meaningful experiences
Hines (1992)	Being available as a unique human being in which there is an exchange of authentic meaningful awareness, and unilateral realisation of human potential
Parse (1992)	The process of becoming
Euswas (1993)	Being there and mindful presence result in inter-subjective connectedness
Boykin and Schoenhofer (1993)	Interconnectedness making it possible to learn, grow and to transcend
Osterman, and Swartz-Barcott (1996)	Being there with focussed energy that reflects varying degrees of intensity
Doona <i>et al.</i> (1997)	Inter-subjective existential experience in which the other is encountered and experienced as a unique being in a unique situation
Covington (2003)	A way of being and relating

(Adapted from Covington 2005:170)

Transposing Paterson and Zderard's (1978 cited by Covington 2005:170) positing of relationships in the nurse-care situation as a reciprocal relationship of availability, openness, mutuality and intimacy implies not only the awareness position of the student nurse towards elements in the clinical situation per se, but also his/her relational awareness involving the clinical tutor. Likewise, the clinical tutor reflects the same availability, openness, mutuality and intimacy. It is further only by, what Watson (1979 cited by Covington 2005:170) refers to as a "conscious awareness relationship resulting in connection" in the clinical setting that the student nurse and tutor, and ultimately the client, fully constitute the presence awareness of the student nurse. In terms of the researcher's understanding, such "conscious awareness" involves more than being merely aware of the presence of elements in the situation. It also includes a deep understanding, or an attempt at understanding these elements, including understanding self.

Roach's (1987 cited by Covington 2005:170) "quality of compassion," with regards to the clinical student nurse's awareness and presence in the clinical learning environment, points towards commitment to the course of his/her clinical learning. Dedication (commitment) to learning in the clinical area stabilises the student nurse's awareness and presence in the clinical learning environment. Such dedication and commitment both flow from, and informs, awareness.

Availability of self, giving, listening, and becoming willingly involved (Pettigrew 1990 cited by Covington 2005:70) in the clinical learning situation operationalise the student nurse's awareness and presence in the clinical field as learning field. Becoming involved *willingly* also points towards commitment. Such involvement is further two pronged; involvement in the clinical area, in the lives of clients, in the day-to-day operations in the clinical field and in his or her learning while in the clinical field. The data explicated in chapter six however implies certain problems in this area as it appears that both students and clinical staff and teaching staff have not come to grips with the education versus service position of students in the clinical area. In this instance see data display 6.1.1.2 and ensuing discussion.

Horner's (1991 cited by Covington 2005:170) indication of "full awareness, receptivity and attention" involves both psychological and physical presence. "Full awareness" in this instance, relates to Ray's (1993 cited by Covington 2005:170) "engaging and interaction" where *engaging* refers to synonymous words such as *promise, oath, covenant, guaranteed* and the like (Rondale 1978).

Swanson-Kauffmann's (1991 cited by Covington 2005:170) "sharing in meanings, feelings and experiences" again position the student nurse in the totality of the clinical field as learning experience involving both the fields of rendering service and the educational component of relating to the clinical staff and clinical tutors.

Gijjn (1993 cited by Covington 2005:170) in addition to the inter-subjectivity that is present in the clinical field as learning field, also introduces the element of "intra-subjective exchange of energy that transforms into meaningful experience." With regard to the student nurse's awareness and presence in the clinical learning field, this points towards continuous self-talk and self-reorientation; of mindfulness and reflection born out of awareness and presence and continuously increasing awareness and presence.

As Euswas (1993 cited by Covington 2005:170) indicates, “being there” and mindful presence result in inter-subjective connectedness. This also relates to Hines’ (1992 cited by Covington 2005:170) notion of being available as a unique human being in which there is an exchange of *authentic* meaningful awareness, and realisation of human potential. Awareness and presence of the student nurse in the clinical field as learning experience can only be accurately perceived if the student presents self in an authentic manner which in turn points towards self-awareness, intra-subjectivity and the uniqueness of each person. Naturally others (clients and tutors) are also seen and encountered as unique beings in unique situations via the inter-subjective existential experience as indicated by Doona et al (1994 cited by Covington 2005:170).

Learning and experience, by its very essence, spell “human becoming.” With regards to Parse’s (1996 cited by Covington 2005:170) “process of human becoming” the researcher views student awareness and presence in the clinical learning field as an accompanying “dynamic equilibrium.” It is a continuous readjustment and reorientation; the constitution of a life-world in the clinical setting; creating the possibility to learn, grow and to transcend (Boykin & Schoenhofer 1993 cited by Covington 2005:170), all founded on and expanding *awareness*.

### **7.2.5 Awareness implied in nursing theories and models**

In addition to briefly looking at the concept “caring” in nursing and nursing theories to illuminate the researcher’s conceptualisation and understanding of student awareness and presence in the clinical area as pivotal to learning, the researcher also briefly reviewed other concepts contained in different nursing theories in an attempt to put forward her understanding of “awareness” and to indicate points of articulation between student awareness and presence and these nursing theories/models; thus, indicating theoretical structures of nursing that in some way, other than through the caring presence, accommodate the researcher’s understanding of student awareness in the clinical setting.

### **7.2.5.1 Henderson's definition of nursing**

Of the 14 statements made by Henderson to augment her definition of nursing (Furukawa & Howe 2002:86-87) the following two statements reflect elements relating to awareness and presence in its broader sense.

**Statement 12:** Work in such a way that there is a sense of accomplishment (Furukawa & Howe 2002:87).

**Statement 14:** Learn, discover, or satisfy the curiosity that leads to development . . . (Furukawa & Howe 2002:87).

It is hardly conceivable that without a presence awareness of where one finds oneself at any moment in time and where one is heading towards that one would be able to experience a sense of accomplishment. Likewise, it is inconceivable that curiosity could exist without some awareness and vice versa.

### **7.2.5.2 Orem's Self-care Deficit Theory**

Orem's (2001 cited in Foster & Bennett 2002:133) definition of the human being strongly suggests awareness as she states that human beings "are distinguished from other living things by their capacity to reflect on themselves and their environment . . ." This "reflection" upon self and the environment clearly indicates "awareness and self-awareness" and, within the Self-care Deficit Theory, reaches its peak in the attainment of being a "self-care agency." Put in educational terms, within the clinical learning field, the "supportive-educative system" as defined by Orem (2001 cited in Foster & Bennett 2002:132) implies that the individual is "able to perform or can and should learn to perform required measures of externally and internally oriented therapeutic self-care, but cannot do so without assistance". Thus the student nurse is educationally at a supportive educational level; supported by the clinical tutors and other nurses in attaining "self-care" in the educational setting, where self-care implies lifelong self-directed learning. This also implies the attainment of self-care agency in educational terms; a life-long process referred to as "self-realisation and personality development" (Foster & Bennett 2002:134) in educational terms. Ultimately this leads towards the final outcome of nursing education namely the production of a professional nurse who keeps

abreast with development in her professional sphere; a dynamic equilibrium of awareness and presence awareness.

### **7.2.5.3 Abdellah's patient-centred approaches**

Six of Abdellah's twenty-one nursing problems (Falco 2002:176) point towards the concepts of *awareness* and *presence*. These are:

**Problem 11:** Maintaining sensory functions

**Problem 12:** Identifying and accepting positive and negative expressions, feelings and reactions

**Problem 15:** Promoting and maintaining productive interpersonal relationships

**Problem 16:** Facilitating progress towards achievement of personal spiritual goals

**Problem 18:** Facilitating awareness of self as an individual with varying physical, emotional and developmental needs

**Problem 19:** Accepting optimum possible goals in the light of limitations, physical and emotional.

The latter two of these "problems" might be of special interest to the student nurse and the clinical educator.

### **7.2.5.4 Wiedenbach's Descriptive Theory of Nursing**

A pertinent statement on Wiedenbach's beliefs about the individual that supports awareness and presence is statement number five (of five statements), namely that "self-awareness and self-acceptance are essential to the individual's sense of integrity and self-worth" (Bennett & Foster 2002:212). It is, however, Wiedenbach's statements on the characteristics of a professional person that intimate awareness. These characteristics are:

- Clarity of purpose
- Mastery of skills and knowledge essential to fulfilling the purpose
- Ability to establish and sustain purposeful working relationships with others
- Interest in advancing knowledge in the area of interest and in creating new knowledge

- Dedication to furthering the good of mankind rather than to self-enrichment (Bennett & Foster 2002:212)

#### **7.2.5.5 Roy's Adaptation Model**

In the Roy Adaptation Model (Galbreath 2002:301), it is the concept “cognator” that pertinently points towards *awareness*. “The cognator processes are related to the higher brain functions of perception or information processing, learning, judgement, and emotion” (Galbreath 2002:303). In addition, the whole process of *adaptation* implies *awareness*. Stimuli input, throughput and eventual adaptive response output cannot be attained without awareness or perception. Within the clinical setting as learning environment multiple stimuli, both internal and external (interpersonal and extra-personal) impinge on the student. Effective and ineffective adaptive responses pertain to students’ adaptation to the clinical environment, the attainment of educational and training goals and outcomes and interpersonal relationships. The *psychological modes* of adaptation of self-concept, role-function and interdependence as stipulated by Roy (Galbreath 2002:304) are all central to learning and transition from student to professional person and being *aware* via feedback systems to the *cognator*.

#### **7.2.5.6 Paterson and Zderad's Humanistic Nursing**

Paterson and Zderad pertinently include *presence* as a component of “dialogue” in their nursing model. *Presence* pertains to “the quality of being open, receptive, ready, and available to another person in a reciprocal manner” (Praeger 2002:390). Naturally, “another person” comes with his or her “situation” and is as such part of the person being present’s situation. Presence is not merely being attentive, but being open to the whole experience in any moment in time. Paterson and Zderad’s phases in Phenomenological Nursology imply awareness and the *creation* of awareness. This is understandable as phenomenology is the science and philosophy of experience, understanding and awareness (Researcher’s condensed definition of phenomenology based on the contents of chapter 2). These phases, listed by Praeger (2002:391-2) are paraphrased for the purpose of the present discussion as:

- Preparing for coming to know
- Knowing intuitively

- Knowing scientifically
- Complementarily synthesising what is known
- Refining the intuitive gap.

The researcher understands Phenomenological Nursology in terms of awareness and presence, as a process of moving from an objective distant awareness and relative absence to an involved and lived presence; of the student nurse as moving from merely possessing fragmented and even disconnected knowledge and experience to an integrated lived whole.

#### **7.2.5.7 Watson's Theory of Transpersonal Caring**

“Watson situates nursing within the postmodern worldview, which acknowledges the holistic and the interconnected nature of the universe and the importance of subjectivity” (Kelley & Johnson 2002:407). *Awareness* as perceived by the researcher at this point is reflected by Watson's definition of ontology (social reality and being) as “meaning of the experience as lived” (Kelley & Johnson 2002:407). *Awareness* is also pertinent in the “latent dimensions” that evolved from Watson's work namely: *Phenomenal field/unitary consciousness* (I italicised): unbroken wholeness and connectedness of all (subject-to-object-person-environment-universe-all living things)” (Kelley & Johnson 2002:409). Of Watson's original ten carative factors, Factor 3: “Being sensitive to self and other” (Kelley & Johnson 2002:412) clearly defines awareness. It is the researcher's contention that this carative factor is foundational to the other nine factors.

#### **7.2.5.8 Parse's Theory of Human Becoming**

It is the researcher's contention that Parse's Theory of Human Becoming is closely related to awareness. Becoming, though in this theory pertaining to health, also forms part of what education in general has in mind.

Parse's theory is based on Rogers' principles and concepts borrowed from the works of Heidegger, Sartre, and Merleau-Ponti on existential-phenomenology, the meta-theoretical framework underlying the present study. Awareness, as human condition, is implied in all these philosophical exponents' work and in phenomenology in general. Though the term “awareness” is not a pertinently defined major concept in Parse's

Theory of Human Becoming, it is clearly implied by specific terminology within the theory such as: co-existence, co-constitution and freedom of choice (Hickman 2002:427). Further of central appeal to the present research into student learning in the clinical environment is Parse's "simultaneity paradigm" concept (Parse 1978:136 cited in Hickman 2002:427). According to this paradigmatic viewpoint, the individual is "more than and different from the sum of the parts . . . an open being free to choose in mutual rhythmical interchange with the environment . . . gives meaning to situations and is responsible for choices in the moving beyond what is . . . experiencing the what was, is, and will be all at once . . ." (Parse 1978:136 cited in Hickman 2002:427). In addition, the simultaneity paradigm focuses on optimal well-being of the individual (Hickman 2002:428). This is also pertinent to the clinical field as learning field; the experience (awareness) of what is, was and could be in the attainment of optimal *health* (professionalism), in essence *becoming* a professional nurse.

Such "becoming" is supported by the following three assumptions that crystallised from Parse's original nine assumptions underlying her theory of Man-Living-Health (Hickman 2002:430). Human becoming is:

- Freely choosing personal meaning in situations in the inter-subjective process of relating and value priorities.
- Co-creating rhythmical patterns of relating in open interchange with the universe (the total environment. Researcher's interpretation).
- Co-transcending multidimensionality with the unfolding possibility (Parse 1988:28-29 cited in Hickman 2002:432).

The latter assumption is of special interest as "unfolding possibility" points directly towards "becoming" and student development within the clinical learning environment; of "moving beyond the self at all levels of the universe as dreams become realities" (Hickman 2002:432). However, of more immediate importance regarding *awareness*, and a theoretical understanding of the clinical environment as learning field, are Parse's structural elements which include: three principles derived from the underlying assumptions and which intimates meaning, rhythmicity and transcendence; and nine (3x3) accompanying concepts.

Principle one postulates: “Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging” (Hickman 2002:433). Of importance to the present study is that this principle implies that the meaning attributed to reality is based on *lived experience*. This is also a central tenet to the present research methodology and meta-theoretical point of departure. Central concepts relating to this principle are imagining, valuing and languaging. Meaning changes (which can also loosely be interpreted as awareness) can be stretched to different possibilities based on the lived experience. With regard to the student in the clinical area, changing and stretching of meaning indicates learning and development with others; co-creating reality (Hickman 2002:433). In addition the plural word *possibilities* indicate the fact that though outcomes are planned in the learning environment the reality of such outcomes and the individual way of attaining outcomes are manifold. As Hickman (2002:433) indicates, *languaging* pertains to images and values through the spoken word and motion. *Valuing* represents the process of living cherished beliefs while adding to one’s personal world view; imaging involves knowing and includes both explicit and implicit knowledge.

Principle two postulates: “Cocreating rhythmical patterns or relating is living the paradoxical unity of revealing-concealing, enabling-limiting and connecting-separating” (Hickman 2002:434). Where principle one relates more to the individual in general and thus to the student nurse in everyday terms, principle two finds more pertinent application to the present research. This principle extrapolates opposites or paradoxes and argues that becoming involves the set opposites of revealing-concealing, enabling-limiting, and connecting-separating (Hickman 2002:434). In broad terms these paradoxes are also reflected in the research findings. The major categories of learning and the erosion of learning in the same setting reflect this. Most enticing (and a point that needs to be addressed in future research) is that if the existential baseline of the individual is taken as “learning” (or experience), the category of “non-learning” could mistakenly be considered the paradoxical counterpart of “learning.” In fact “non-learning” is still learning. So, conceptualising a “non-learning/learning” paradox still maintains the original three counter points. Within the “non-learning” experience, something is still revealed (such as something about the individual student or a certain subjective awareness) and something is still concealed (such as the positive which could have been learned from the situation); the student still connects (perhaps to an anti-practice dogma) and separates (from the clinical learning experience); and still is

enabled to distance self from the clinical learning field thereby limiting involvement and expected learning.

On a more positive note, clinical learning also reflects the three opposites. One can say positive learning reveals, enables and connects the student. Much about the clinical situation is revealed through clinical experience but it also conceals certain aspects as everything cannot be known and experienced. In addition, curriculum content is often focussed to the point of excluding (concealing) certain experiences. The aim is certainly to “connect” the student to clinical practice which may separate students from certain theoretical aspects (in the case of the ever present theory-practice gap). Similarly, clinical learning enables the student nurse within the clinical field and it could limit, for instance, sophomore impetuosity. In the same vein, the three paradoxes apply to *awareness*. ***Awareness is a revelation that enables and connects*** (the researcher’s intermediate definition).

Principle three postulates: “Cotranscending with the possible is powering unique ways of originating in the process of transforming” (Hickman 2002:435). Central themes from this principle are powering, originating and transforming.

According to Parse (Hickman 2002:435) powering is “an energizing force the rhythm of which is the pushing-resisting of interhuman encounters.” With regards to the present research and the core concept of awareness, it is the researcher’s conviction that awareness underlies “powering.” In addition, it is awareness that primarily “pushes” or “resists” inter-human interactions. Moreover, it is awareness that powers pushing-resisting interaction with any element in the environment or, as Parse (1981 cited in Hickman 2002:435) insists, the universe. Awareness is most akin to powering as it emerges from revealing-concealing of valuing. Thus awareness is also empowering. This becomes the force behind originating and transforming. Put differently awareness as the core element in clinical learning propels (originates) the student towards transforming (becoming and turning into a nurse professional).

Originating is “inventing new ways of conforming-not conforming in the certainty-uncertainty of living” (Parse 1981:98 cited in Hickman 2002:435). “It is creating ways of distinguishing personal uniqueness by living out the paradoxical rhythms all-at-once” (Hickman 2002:435). Originating as initiating and creating, has special applications and

implications with regard to the present research findings. Many of the categories imply *conforming* (Data display series 6.1.2 on benefits of the clinical field as learning experience. Data display series 6.1.5 on what is learned in the clinical field and theme 3 on motivational factors), whereas others imply “not conforming” (Theme 4 on erosive factors). Further, the clinical arena is flawed with uncertainty. Although the general aim of education and training might be to instil a sense of certainty in students, this is in fact deceptive as it merely assists in creating awareness which is a continuous process of adaptation and adjustment akin to constituting a life world. This ultimately leads to *transforming*; defined as “the changing of change” and recognised by increasing diversity (Parse cited in Hickman 2002:435). The concept of “changing of change” is of the utmost importance here as it indicates that even change has no predetermined trajectory. Whatever we do, or refrain from doing, changes “change.” The best we can equip ourselves with is thus the will and ability towards presence-awareness; presence and awareness in and of change.

## **7.2.6 Awareness and learning theories**

Awareness, explicated in terms of “presence awareness,” (section 7.2.1) as the answer to “Where am I?” relates mainly to two directions of thought in educational psychology namely cognitive learning theories and humanistic learning theories. It is the researcher’s contention that to be able to “do” something both cognition (knowledge) and feelings or emotions are involved and are essential in addition to dexterity. For this reason less emphasis is placed on behaviouristic learning theories. Within the researcher’s conceptualisation of “awareness” as the central, all encompassing human faculty (category) that accommodates all dimensions of the data as explicated in chapter 6, humanistic learning theories take precedence over cognitive learning theories. The major reason for this is that the philosophy underlying humanistic learning theories is most appealing to the researcher. As Quinn (2000:51) indicates: “Humanistic theory is closely related to the philosophical approach called phenomenology . . .;” the philosophy and methodology underlying the present research.

### **7.2.6.1 Cognitive learning theories**

“The term cognition refers to the internal mental processes of human beings, and encompasses the domains of memory, perception and thinking” (Quinn 2000:66). For

the purposes of the present discussion on *awareness* as an all encompassing concept and human capability accommodating all dimensions of the data presented in Chapter 6, perception takes centre stage (with the acknowledgement that this cannot occur without memory and thinking). Quinn (2000:73) accordingly defines perception as “an organised process in which the individual selects cues from the environment and draws inferences from these in order to make sense of his [sic] experience.” Given the status of cognitive theories as “in-between” behaviourism and humanism, the rather “objective” nature of perception, as defined by cognitive theorists, is understandable.

Awareness, in cognitive terms figures most prominently in cognitive operations such as critical thinking, intuition and problem solving, including problem-based learning and decision-making. These mental and cognitive processes are all central to nursing practice and consequently also to student learning in the clinical field (Quinn 2000:79-87).

The ultimate in awareness with regard to cognition is meta-cognition. Leahey and Harris (1993:236) define *meta-cognition* as “The knowledge, awareness and monitoring of one’s own cognitions . . .” Similarly, Mayer (1992:256) defines meta-cognition as “awareness of one’s own cognitive processing.” Meta-cognition is in a sense understanding the way in which one understands; being aware of the way in which one learns. This becomes vitally important in the clinical versus the classroom setting when learning styles, for instance, *field dependence* versus *field independence*, and *reflective* versus *impulsive* learning styles are considered (Quinn 2000:33). It might be argued that field dependent oriented students might learn more from the social aspects present in the clinical field than would field independent students. On the other hand, field independent students might be more self-directed in the clinical field, especially with regard to problem-solving and more *techno-tronic* issues in the clinical field (Quinn 2000:33). In the same vein, the reflective students might be more secure in the clinical field than might be the impulsive student (Quinn 2000:33). With regard to specific cognitive learning theory, the extent to which a balance between the implementation of principles from Ausubel’s assimilation theory of meaningful learning (Quinn 2000:91-96) and Bruner’s discovery learning (Quinn 2000:96-99) will be maintained in the clinical learning environment will ultimately be determined by students’ meta-cognition (awareness) and clinical tutors’ and staff members’ appreciation hereof. Placing students in situations in conflict with their innate cognitive style, may in fact be a case of

placing students in a position created to diminish their perception and awareness in that situation, thereby stifling learning.

It is also at this point that cognition and cognitive theory articulate with practice and skills; motor learning. The link resides in Quinn's (2000:88) contention that *procedure* refers to an intellectual skill consisting of rules for sequencing actions and *motor skill* as the ability to execute a procedure. Awareness as "Where am I?" at this point reaches a micro level of the individual student's awareness of his/her "position" within a single procedure and of the procedure amidst everything the student already knows and can do. It definitely also relates to both the levels of maturation-dependent skills (such as walking, speaking and the like) and educational-related skills (such as reading, writing and observing) (Quinn 2000:88).

#### **7.2.6.2 Humanistic learning theories**

According to Quinn (2000:51), there is not single theory that represents the humanistic approach. "However, all theories share a common view that this approach involves the study of man [sic] as a human being, with his feelings, thoughts and experiences" (Quinn 2000:51). This is in direct opposition to both the cognitive and the behaviourist approaches to learning. The general complaints levelled at these two approaches by humanists are that behavioural theories disregard the inner feelings and experiences of individuals and cognitivists are too focused on the thinking aspects of the individual leading to the neglect of affective components (Quinn 2000:51).

Apart from the humanist integration of thinking and feeling, humanists also emphasise self-direction, empowerment and autonomy (Quinn 2000:52), all intensely important issues in clinical learning and professional becoming, requiring awareness and reflecting awareness.

Apart from Maslow's, and Rogers' contributions to humanistic learning theorising with regard to learning in the clinical environment, the student nurse as approaching adulthood (if not a young adult or adult proper already), and awareness as innate human attribute, *andragogics* (adult learning) as a branch of humanistic learning theory, becomes important.

The importance of andragogics in both establishing and maintaining awareness in the clinical learning environment is clearly reflected by the following tenets of andragogics as postulated by Tennant (in Quinn 2000:61):

- *Valuing the experience of learners.* Learners in the clinical field have different life experiences and experiential knowledge that in a sense steer their perception and consequently their awareness. These must be taken into consideration over and above having a positive attitude towards students.
- *Engaging in reflection on experiences.* Both as a teaching strategy and a way of life, reflection (and ultimately mindfulness) both activates and maintains awareness.
- *Establishing collaborative learning relationships* This leads to enrichment through multiple perspectives, without unnecessary reiteration, improving awareness.
- *Addressing issues of identity and power relationships between students and tutors.* Those relate directly to the student's question: "Where am I?" and "Who am I?" in the clinical field and professional developmental hierarchy.
- *Promoting judgments about learning which are developmental and which allow scope for success for all learners.* Though this statement does not directly relate to awareness, it is argued that mis-perception and faulty awareness (judgment) might contribute towards a lesser chance of success. The relativity of success might also be a relative indication of "awareness."
- *Negotiating conflicts over claims to knowledge and pedagogical processes.* In this regard, students should be encouraged to express different opinions on matters of concern to learning in the clinical area. This again can only contribute positively towards the student understanding and appreciating her individual position and stance in the clinical learning environment. (See data display series 6.4.3 on student perceptions of clinical staff for instance.)

- *Identifying the historical and cultural locatedness of experiences*:. The major issue is to question assumptions based on these two areas of human experience as these influence awareness.
- *Transforming actions and practices*. This is perhaps the single most important issue relating to andragogics and awareness in the clinical learning environment. Awareness of transformation and viewing awareness as a dynamic equilibrium, as an adaptive process, are essential to integrate different knowledge sources and bases and to learn and grow through such integration. (In this instance see data display series 6.1.6. on sources and resources of knowledge.)

### **7.3 AWARENESS AND CRITICAL CROSS-FIELD OUTCOMES**

According to Jacobs, Vakalisa and Gawe (2004:95), critical outcomes are relatively recent innovations in curriculum design. According to Spady (1994:51 cited in Jacobs et al 2004:95), “Critical outcomes are core performance abilities that learners will use throughout their school careers and in their adult lives. They are things that really matter to learners in the long run and cannot be developed inside of any segment of the curriculum.”

In South Africa, critical outcomes are described by the Department of Education (Department of Education 2002:11). These outcomes are grouped into two broad categories namely seven critical outcomes and an additional five developmental outcomes. The critical outcomes are especially important to the present discussion on *awareness*.

*Awareness* as the central all accommodating concept derived from the data obtained during the current research relates to critical outcomes in three ways.

- Awareness, as a predisposition, is of primary importance in order to attain these outcomes
- Awareness as a collective outcome established and attained by all these critical outcomes
- Awareness by its very nature constitutes a critical outcome to be pursued.

The general aim of allocation of student nurses to the clinical field is clinical teaching and learning, with the latter the phenomenon under investigation in the current research, clearly supports all the critical outcomes stipulated by the Department of Education. *Awareness* also provides a specific dimension to these. To illustrate this, each of the critical outcomes as listed by Jacobs et al (2004:96-109) will be discussed briefly.

### **7.3.1 Awareness and critical outcomes**

***Critical outcome #1:*** *Learners will identify and solve problems and make decisions using critical and creative thinking.* As critical and creative thinking stem from a repertoire of knowledge, skills and experiences, awareness represents both the incidence of these knowledge, skills and experiences as well as the outcomes of the confluence of these elements to identify and solve problems. Identifying problems, in addition, depends on existing “awareness” the individual has with regard to the broader context within which any potential problem exists. Whether a problem is actually solved or not solved by the learner, the outcome contributes towards the learner’s educational and learning experience and consequently to his or her awareness in a more holistic and integrated sense.

***Critical outcome #2:*** *Learners will work effectively with others as members of a team, group, organisation or community.* Though this is one of the primary aims for student nurses to be attained during clinical placements, based on the categories that emerged from the data, it appears that student nurses do not always find themselves pursuing this outcome. See theme 4 on erosive factor for instance. Not feeling “one” of the team members, lingering and absencing self from the clinical field all contribute towards this outcome being endangered. However, this outcome, by its very nature and construct, assumes *awareness* on the part of the learner, of knowing where he or she finds him/herself within the clinical hierarchy to be able to work effectively with other team members. Clinical staff and clinical teachers should also be aware of the position of the student in the clinical area to involve him or her in effective cooperation at the level of academic and professional development of the individual student.

***Critical outcome #3:*** *Learners will organise and manage themselves and their activities responsibly and effectively.* This again is an overarching outcome (aim) of clinical

placement and learning for student nurses. However, without an awareness of “Where am I?” student nurses might find themselves at a loss as to how to organise and manage their activities in the clinical field. A broad understanding of the total context is called for in order to allow for student nurses as learners to be able to attain this outcome.

**Critical outcome #4:** *Learners will collect, analyse, organise and critically evaluate information.* In this instance it is argued that learners will be more successful in collecting, analysing and critically evaluating information in the clinical area in accordance with their levels of expanded, integrated and holistic awareness or understanding of the clinical field. Such *awareness* includes anticipation of the possible alternative outcomes of the confluence of the multi-dimensional elements within the clinical (life) arena. Attaining this outcome again implies the self-impregnating nature of “awareness.”

**Critical outcome #5:** *Learners will communicate effectively using visual, symbolic and/or language skills in various modes.* With regard to “awareness,” this critical outcome calls for *other* awareness in addition to self-awareness. Within the clinical field as learning field, the student nurse learns to communicate different messages under different circumstances to different members of the health team at different levels of acuity and urgency. Both cognitive and affective elements are pronounced in these communications and messages. Awareness of the other’s (including the student nurse him/herself to whom communication is addressed) level of professional and academic advancement need to be taken into consideration. Again, awareness becomes more encompassing as it involves intra (self), inter (other) and extra-personal (contextual) awareness.

**Critical outcome #6:** *Learners will use science and technology effectively and critically, showing responsibility towards the environment and the health of others.* At this point awareness can be illustrated with the concepts “received view” and “perceived view.” A received view of self and the environment takes on a deterministic quality, of the environment and individual forming two unconnected and uninvolved entities. Such a view by definition would exclude, or at least hamper, the concept *awareness*. With a perceived view, however, contextual and environmental elements are internalised and, as the word *perception* implies, are interpreted in terms of an existing value system

within the person perceiving these contextual and environmental elements. Awareness of the context and environment thus aids in the constitution of a life-world.

**Critical outcome #7:** *Learners will demonstrate an understanding of the world as a set of related systems by recognising that problem-solving contexts do not exist in isolation.* This outcome essentially relates to the previous outcome and illustrates the ultimate in personal awareness of nursing students within the clinical arena. Awareness, as defined up to this point, clearly indicates its multi-dimensionality and consequently an appreciation for the fact the “nothing” exists in total isolation. It is only through such awareness that problems can be anticipated and identified whenever they occur. This also intimates *mindfulness*.

### **7.3.2 Awareness and developmental outcomes**

Development by its very essence is dependent upon awareness in its complete multi-dimensional manifestation. Again, awareness is both an antecedent to development and an outcome of development. A brief indication, where applicable and applicable, of the way in which the developmental outcomes formulated by the Department of Education (Department of Education 2002:11) relate to awareness and vice versa would suffice at this point of the discussion.

**Developmental outcome #1:** *Learners should reflect on and explore a variety of strategies to learn more effectively.* The term “reflect on” indicates awareness. Further, expanding awareness through a variety of teaching strategies is clearly indicated in data display series 6.1.4 on teaching strategies that emerged from the clinical field.

**Developmental outcome #2:** *Learners should participate as responsible citizens in the life of local, national and global communities.* Clinical practice in nursing today involves students in all these spheres. The integrated holistic awareness proposed in this chapter also implies an understanding of the dynamics among these fields.

**Developmental outcome #3:** *Learners should be culturally and aesthetically sensitive across a range of social contexts.* With regards to aesthetics, the reader is reminded of the art and science of nursing, where the art of nursing represents the aesthetic element

of the profession as explicated in the discussion ensuing data display series 6.1.5 on what is learned in the clinical field..

***Developmental outcome #4:*** *Learners should explore education and career opportunities.* In this regard it needs to be pointed out that students are already in a profession and have embarked upon a career.

***Developmental outcome #5:*** *Learners should develop entrepreneurial opportunities.* This outcome does not really have bearing on the concept of awareness apart from being aware of the fact that private entrepreneurial possibilities do exist.

#### **7.4 AWARENESS AND LEARNING OUTCOMES (DOMAINS OF LEARNING)**

According to Jacobs at al (2004:90), regardless of the controversy surrounding the issue, outcomes and objectives in the educational setting are synonymous. This statement allows for revisiting the different domains of learning foundational to learning and teaching objectives and outcomes. It appears that the emphasis on these learning domains have diminished over the past decade. However, revisiting these domains is important if awareness in its multi-dimensionality, as an integrated holistic concept and a way of being, is to be cultivated within students in the clinical learning filed. Thus, in line with the central theme of this chapter, revisiting these domains of learning is also done from the point of view of illustrating the way in which awareness manifests itself within the different domains of learning. The three learning domains, namely the cognitive, affective and psychomotor domains, are revisited by using a classic source in this regard in nursing education namely Reilly (1980).

As will become evident, some of the synonyms of the word “awareness” have also found their way into the construction of the different levels of the three major learning domains; the cognitive, affective and psychomotor domains. This is understandable as the term “awareness” figures in different academic fields and has varying degrees of correspondence in meaning among these fields. The MSWord thesaurus (MS Word 2003 Thesaurus) also lists the following synonyms for the word “awareness” at the more colloquial level of speaking: consciousness, alertness, responsiveness, attentiveness, knowledge, understanding and grasp.

#### 7.4.1 Awareness and the cognitive domain

Reilly (1980:47-54) based her discussion of the taxonomy of the cognitive domain on the work of Bloom et al (1956). The cognitive domain addresses cognitive (knowledge) learning and mental reworking of knowledge. This is corroborated by Quinn (2000:140).

The lowest level of the cognitive domain, labelled *knowledge*, involves the recall of specifics, universals, patterns and structures. Recall implies that the individual is familiar with phenomena in a most basic manner (Quinn 2000:141). To *know* at this level is at least to know that something exists, the most foundational antecedent to eventual holistic *awareness*.

Following the knowledge level of cognition is the level of *comprehension*. According to Reilly (1980:50) this represents the first level of intellectual skill and, in addition to recall, involves translation, interpretation and extrapolation. Quinn (2000:142) indicates that the learner makes limited use of information at this level. Nonetheless, it is foundational to forming an integrated whole in awareness expected from students in the clinical learning field and also of professional practitioners. As such, *comprehension* is the first step in what the researcher would call the creation of awareness; a *perceived* dimension of awareness in addition to a more *received* dimension at the mere knowledge level.

At the *application* level of the cognitive domain, intellectual skills relating to *using* knowledge become operational. Concepts, processes and the like are applied (theoretically) to situations within the clinical arena (Quinn 2000:142). This is a step in directing intra-psychic awareness towards the extra-personal and even inter-personal spheres of awareness.

Following *application* is the level of *analysis*. At this level of cognitive learning, emphasis is placed on the breaking down of material into its constituent parts, detecting the relationship of parts and the way they are organised (Quinn 2000:142). Reilly (1980:51) mentions the analysis of organisational principles. This could be of primary importance to allow student nurses to appreciate their position within the hierarchy established in the clinical area. As indicated previously, a fundamental position from which to answer the question; "Where am I?"

Reilly (1980:53) indicates that the four levels of the cognitive domain as explicated up to this point all contribute towards understanding “concept formation;” the foundation to creating awareness in the clinical field. However, the levels of *synthesis* and *evaluation*, or as Reilly (1980:53) indicates, the combined level of *creativity*, are vitally important in consolidating all cognitive learning into *awareness*. Although Quinn (2000) does not make this combined statement on the two most advanced levels of the cognitive domain, her basic definitions are the same as those of Reilly (1980). It is the mental or cognitive operation of *synthesis* that allows for unique communication (a definite indication of awareness as defined within the scope of this chapter) and *evaluation*, the level at which judgment in terms of internal criteria or external criteria are given in the process of decision-making.

Awareness in terms of cognition thus follows a developmental route from mere knowing that something exists to the point where knowledge is integrated in the continuing change of life patterns such as the development of the student nurse in the clinical field through learning; encompassing awareness that figures in adaptation through problem-solving.

Table 7.3 summarises major concepts and words relating to cognitive thinking and creative thinking which further illustrates the researcher’s conceptualisation of an integrated holistic awareness of students in the clinical learning field. This table is adapted from Lipman (2003:259).

<b>TABLE 7.3: SUMMATION OF CONCEPTS ASSOCIATED WITH COGNITIVE THINKING (CREATIVE THINKING)</b>			
<b>IMAGINATIVE</b>	<b>HOLISTIC</b>	<b>INVENTIVE</b>	<b>GENERATIVE</b>
Defiant	Self-transcendence	Experimental	Maieutic
Bright	Unified	Surprising	Productive
Expressive	Concordant	Original	Fecund
Passionate	Integrated	Fresh	Fruitful
Visionary	Coherent	Inquisitive	Fertile
Fanciful	Orderly	New	Controversial
Articulate	Organic	Independent	Stimulating
		Un-dogmatic	

(Adated from Lipman 2003:259).

## 7.4.2 Awareness and the affective domain

The affective domain of learning “relates to ethics, standards or principles of moral actions; moral judgement, the reasoning compatible with standards of right behaviour; value indicators such as attitudes, interests, beliefs, and goals; and values themselves (Reilly 1980:54). According to Quinn (2000:140), the affective domain relates to attitudes, values, interest and appreciation.

The lowest level of the affective domain entails *receiving*; sensitivity towards the existence of a phenomenon, condition, situation or problem. This corresponds to the lowest level of the cognitive domain namely *knowledge*. *Receiving* excludes *perceiving* or *perception*, a value laden interpretation by the individual. According to Reilly (1980:57), receiving involves *awareness* (not in the sense that it is defined in this chapter but merely as being aware of), *willingness* to receive and controlled or *selected attention*. This is corroborated by Quinn (2000:145). These are important with regard to the present explication of awareness as, if willingness to respond does not occur, “awareness” will be encapsulated and will fossilise. Equally, even though selected attention indicates progression towards a more holistic awareness, selectivity might exclude some important aspects of the phenomenon and might equally lead towards the encapsulation of “awareness.”

The second level of the affective domain involves *responding*; “reacting overtly to a stimulus or phenomenon, and doing something with or about it” (Reilly 1980:58; Quinn 2000:144). It is, however, at the third level of the affective domain, the level of *valuing* that internalisation that the more holistic nature of awareness as defined in this chapter, takes on shape (Quinn 2000:144). Self-awareness, or at least already existing value systems within the individual, plays an important role at this levels as valuing involves the *acceptance* of a value, *preference* for a value and *commitment* to a value (Reilly 1980:59). At this point what was originally received turns into being perceived and with this comes the involvement of different things already being aware of, or, the creation of a “new” awareness within the individual. For the student nurse in the clinical learning field this is a major step in professional development; of internalisation of professional values. Following on valuing is the level of *organisation* in which values are being prioritised into a value system following the deliberation of their interrelationships and relative values (Quinn 2000:145). The fact that different values are involved in this value

system and the fact that these are being prioritised progresses towards an integrated holistic *awareness*.

Finally, the individual arrives at a stage of *characterisation by a value or a value complex* (Quinn 2000:145; Reilly 1980:60). Of ultimate importance in the quest to develop and secure *awareness* within the individual student nurse, is the attainment of a *generalised set*: “Basic orientation that enables the individual to reduce and order the complex world about him/her and to act consistently and effectively in it” (Reilly 1980:60). “Internalisation of a value system having as its object the whole of what is known, or knowable, with an internal consistency” (Reilly 1980:60) is known as “characterisation”.

To further illustrate the researcher’s conceptualisation of an integrated holistic awareness of student nurses in the clinical learning field, table 7.4 exhibits concepts and words associated with caring thinking as explicated by Lipman (2003:271).

**TABLE 7.4: SUMMATION OF CONCEPTS ASSOCIATED WITH CARING THINKING (AFFECTIVE DOMAIN)**

APPRECIATIVE	ACTIVE	NORMATIVE	AFFECTIVE	EMPATHETIC
Prizing	Organising	Requiring	Liking	Considerate
Valuing	Participating	Obliging	Loving	Compassionate
Celebrating	Managing	Compelling	Fostering	Curatorial
Cherishing	Executing	Appropriate	Honouring	Nurture
Admiring	Building	Enforcing	Reconciling	Sympathetic
Respecting	Contributing	Demanding	Friendly	Solicitous
Preserving	Performing	Expectant	Encouraging	Mindful
Praising	Saving			Serious
				Imaginative

(Adapted from Lipman 2003:271)

### 7.4.3 Awareness and the psycho-motor domain

Although human behaviour is a holistic phenomenon, involving all three the basic learning domains, the psychomotor domain for the purposes of the present discussion entails “those behaviors which include muscular action and require neuromuscular coordination (Reilly 1980:61). Quinn (2000:140) merely indicates that this domain involves *motor skills* learning.

In line with the lowest level of learning in the other domains, the first level of psychomotor learning entails mere *imitation*. At this level the learner, when exposed to

observable actions, starts making covert imitations (replications) of those actions (Reilly 1980:81). Quinn (2000:147) refers to this level of development as *perception*: ranging from awareness of stimuli to translating these into action. This is followed by repeated actions and imitations resulting in *manipulation* as the second level of development in the psychomotor domain. At this level the learner is able to perform an act according to instruction rather than by mere imitation. Practice leads to *precision*, a high level of refinement during which accuracy, proportion and exactness in performance become significant (Reilly 1980:63). This is followed by *articulation*, the coordination of a series of acts achieving harmony and internal consistency among different acts and behaviours. At this level, the way in which the researcher perceives holistic integrated awareness in the clinical field becomes apparent. The key word with regard to awareness is integration. Not only are different sets of actions, acts and behaviours integrated, but also knowledge and feelings. This links on to the final and highest level of psychomotor development and learning namely *naturalisation*. In this instance, actions become routinised and smooth, and executed with the least expenditure of psychic energy. The absence of “thinking” at this level of outomisation does not indicate less awareness. It is the researcher’s notion that this in fact, in combination with the other two domains of learning, introduces the concept of *professional* or *educated intuition*, the ultimate in *awareness* in the clinical field. As Quinn indicates, intuition, though perceived as learning and acting almost unconsciously, “may actually be superior in some cases to rational problem solving” (Quinn 2000:84). This brings yet another dimension to the concept of integrated holistic awareness.

Quinn’s (2000:146) alternative levels of development in the psychomotor domain also give a pertinent perspective on creating an integrated holistic *awareness*. In addition to the first level of *perception*, Quinn (2000:146) defines the second level as *set*. This level is concerned with cognitive, affective and psychomotor readiness to act. This holistic readiness logically is appealing to the researcher in conceptualising a holistic integrated awareness.

*Guided response* and the third level of development and learning in the psychomotor domain involve demonstrating skills to learners and allowing them to re-demonstrate these. *Mechanism* represents the point where performances become habitual (Quinn 2000:146). This is followed by *complex overt response* in which instance the learner economises on effort during the execution of skills. After this, skills are internalised, to

such an extent that the learner can adapt (*adaptation*) to changing circumstances and demands. Finally, the learner reaches the level of *organisation*, enabling him or her to organise *new* movement patterns to suit particular situations. It is most interesting to note the verbs suggested by Quinn (2000:146) for assessing this level of achievement. These include verbs such as *compose*, *create* and *design*. Within the present explication of *awareness* as an all encompassing category in current research, these verbs imply a certain alertness and consciousness of many different elements from the cognitive, affective and the psychomotor domains; an integrated holistic *awareness*.

## **7.5 CONCLUSION**

In this chapter, in line with the suggestion made by Wertz (1984:44), that ultimately, in qualitative research, data should be related to a single all encompassing concept, the researcher discussed *awareness* as such a foundational concept in human experience and being. This chapter further indicates the implication *awareness* finds in the data as explicated in chapter 6. This was achieved by a discussion of awareness as it figures and relates to philosophy, social psychology, caring, nursing theories and learning theories from the cognitive and humanist movements and associated learning domains. It is ultimately concluded that the development of awareness amongst students in the clinical area is supported by all the scientific and academic fields mentioned. In addition, such awareness also implies awareness on the part of teachers in the clinical field. These aspects are touched upon in the next chapter as recommendations.

## Chapter 8

### Summary of findings, conclusions and recommendations

#### 8.1 INTRODUCTION

In this, the final chapter, a summary of the research process is given, including a summary of findings, implications, conclusions and recommendations. The major categories and subcategories that emerged from the data are involved in this discussion.

#### 8.2 THE GUIDING RESEARCH QUESTION

The overarching research question that was negotiated with participants was:

- **How do you experience the clinical field as learning field?**

Alternatively:

- **How do you experience learning in the clinical fields?**

#### 8.3 AIM OF THE STUDY

The aim of the study was to gain an empirically based understanding of the experiences of student nurses during clinical facilitation and learning. Deriving from the empirical based understanding theory and guidelines to improve clinical learning and facilitation were developed.

#### 8.4 RESEARCH DESIGN

The research was conducted within the qualitative research paradigm. Moreover, the research process was structured according to Wertz's (1983, 1984, 1985) empirical psychological reflection; an approach within existential phenomenology.

### **8.4.1 Methodology**

In view of the fact that the research question focused on the lived experiences of student nurses within the clinical learning environments, phenomenology served as both a meta-theoretical structure and as methodology.

### **8.4.2 Assumptions on which the research is based**

Instead of departing from a theoretical framework, as is the case in quantitative research, the phenomenological researcher departs from basic assumptions, stated at the ontological, methodological and epistemological levels. Within the dictates of Wertz's (1983; 1984; 1985) existential phenomenology and empirical psychology reflection, the whole study including the assumptions, were articulated on a single existential base line, namely that experience equates to learning.

#### **8.4.2.1 Existential baseline**

Whatever the individual does, the result is learning. Put differently, all human experience result in learning.

#### **8.4.2.2 Theoretical-conceptual assumptions**

With regard to the theoretical-conceptual assumptions of the current study it was assumed that:

- a student nurse as a person is coexisting while co-constituting rhythmical patterns with the clinical learning environment
- man (person) is an open being, freely choosing meaning in situation, bearing responsibility for decisions
- a student nurse can therefore transcend multi-dimensionally with possibilities; (Parse 1998:28-29 cited in Hickman 2002:432)
- the phenomenological method is rooted in the assumption that knowledge of a lived experience becomes known through persons' descriptions of their reality (Smith 1989:16)

### **8.4.2.3 Methodological-technical assumptions**

The methodology of the current study was guided by the following assumptions:

- the application of existential-phenomenology is imperative for the study of individual experiences of learning in the clinical field
- objects and events as they appear and are perceived assume a life-world that is social in nature
- “the world” is assumed to be a subjective and perspectival, reality; a matter of appearances
- being in the world, the world becomes real through contact with it, knowing shapes experience
- a composite of realities, access to realities is a matter of locating and using forms of expression, these give us access to subjects’ realities
- what is logically inexplicable might be existentially real and valid (Swanson-Kaufmann & Schönwald 1988:98)

### **8.4.2.4 Ontological assumptions**

With regard to ontological assumptions it was assumed that:

- individuals can reflect and verbalise role experiences and views regarding learning within clinical learning environments
- qualitative researchers can report faithfully on these realities, and on voices and interpretations of participants (Creswell 1994:4)

### **8.4.3 Sampling**

A purposeful sample of five student nurses from their second to fourth year of academic development in the program leading to registration with the SANC (R425) were selected to participate in the study. Student nurses from second, third and fourth year were selected on the basis of their experience in the clinical learning environment. In addition, student nurses who met the inclusion criteria of the study and who were willing to share their experiences through interviews were considered for participation.

#### **8.4.4 Data gathering**

The researcher conducted individual in-depth, unstructured, formal qualitative research interviews. The guiding research question was put forward, requesting each participant to explore and to exhaust experiences surrounding the contents of the research question. All participants agreed to take part in subsequent member-checking sessions during which the researcher consulted with each participant on her interpretations of what she had said to obtain confirmation that the report captured meaning as constructed by the participants. Member-checking sessions were conducted until participants confirmed congruence between the researcher's interpretations and their original intentions.

Collected data were audio recorded during interviews, transcribed and analysed using open coding and constant comparative analysis.

In selecting in-depth (phenomenological) interviews the researcher was enthused by the fact that such interviews would allow

- illumination of subjective human experiences (Taylor & Bogdan 1984:81)
- both parties to explore the meaning of the questions and answers to questions (Mulaney 1997:166)
- areas of uncertainty or ambiguity to be clarified instantly to avoid misinterpretations (Mulaney 1997:166)

#### **8.4.5 Data analysis**

Data analysis was conducted at the idiographic and the nomothetic levels according to Wertz's empirical psychological reflection. Verbatim transcriptions were analysed to reveal themes categories and sub-categories.

Data analysis was based on the assumptions that

- personal stories of participants express a reality sufficiently unique or cohesive so that any assumptions on the part of researchers will not influence their interpretation

- experiences and knowledge, while valid, may not be the reality researchers seek to describe
- personal stories of participants express a reality sufficiently unique or cohesive so that any a priori assumptions of researchers will not influence their interpretations (Swanson-Kauffman & Schönwald 1988:99)

In accordance with Wertz's suggestions, on completion of the data analysis and logical placement of themes, categories and sub-categories in relation to one another, the researcher identified a single category (concept) that accommodates, or accounts for, all themes and categories. "Awareness" (as discussed in chapter 7) was identified as such an accommodating, all encompassing concept.

#### **8.4.5.1 *The idiographic phase***

Though individual psychological profiles of participants, a summative outcome of the analysis of individual participants' contributions, were not compiled, data analyses were nonetheless completed at the idiographic level first before moving on to the nomothetic level of combining data into complete phenomenal descriptions.

#### **8.4.5.2 *Nomothetic phase***

Analysis at the nomothetic level resulted in:

- 4 Main themes
  - Theme one: Descriptive overview of clinical learning
  - Theme two; The nature of the lived experience of student nurses
  - Theme three: Motivational factors in clinical learning
  - Theme four: Erosive factors in clinical learning
- 16 Categories
- 65 Sub-categories
- 53 Sub-subcategories
- 778 Statements (data units or evidence)

An outline of all themes and categories is provided in section 6.1.1.

#### **8.4.6 Literature support review**

The literature review was conducted to gain a background understanding of the information available on the experiences of clinical learning within the clinical environment as discussed in chapter 3.

Three major areas emerged during the literature review namely:

- overview of the clinical learning environment
- factors promoting clinical learning
- erosive factors in the domain of clinical learning

The major literature review was, however, conducted in the form of theoretical sampling of literature to support themes and categories that emerged from the data reported on in chapter 6.

#### **8.4.7 Trustworthiness**

Trustworthiness was assessed and ascertained in terms of its credibility, transferability, dependability and confirmability (see section 4.7.2). With regards to transferability at least the all encompassing concept “awareness” as explicated in chapter 7, can be *generalised* to all student learning in the clinical area.

#### **8.4.8 Relating the research results to existing theory**

In relating the findings of the current study to existing theory in an attempt to enhance the trustworthiness of the findings and to indicate the practical implication of the findings, the researcher first identified a single category (concept) from the data which accommodates, or accounts for, all other categories and themes. “Awareness” emerged as such a single concept.

The concept *awareness* was related to the fields of computer science, philosophy, social-psychology, nursing theory, learning theory and the domains of learning. The researcher was able to relate the concepts “awareness” to eight nursing theories. Nursing theories based on existential, humanistic and phenomenological philosophy

were found most accommodating of the concept “awareness” as awareness is a central tenet to these philosophies. In this regard, Parse’s theory on “Human Becoming,” appealed most to the researcher and consequently the researcher investigated “awareness” in terms of the theoretical concepts contained in this theory in more detail. The three basic assumptions underlying Parse’s theory of human becoming were most applicable. These assumptions are:

- Freely choosing personal meaning in situations in the inter-subjective process of relating and value priorities.
- Co-creating rhythmical patterns of relating in open interchange with the universe (the total environment).
- Co-transcending multidimensionality with the unfolding possibility (Parse 1988:28-29 cited in Hickman 2002:432).

## **8.5 SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS**

In this section, themes and categories (findings), selected on the basis of their association with *awareness (or being connected)*, are discussed as findings. Conclusions are drawn from these findings and recommendations are made, based on the conclusions.

### **8.5.1 Theme 1: Descriptive overview of the clinical learning environment**

#### **8.5.1.1 CATEGORY 1: The concept “learning” in the clinical field (Data display: 6.1.1)**

##### **Finding:**

In this category students indicated the importance of “doing the right thing” and differentiating between learning and working. Repetitious work is considered not to be learning.

##### **Conclusion:**

Even though students already have an idea (awareness) of what is expected of them in the clinical setting, students might miss out on the value of repetition in automating certain psychomotor skills and even in patterns of argumentation. This could also

influence students' perceptions of their status as learners in the clinical field and performing skills that could attribute to the outcomes of learning in the clinical field. Students need to strike a balance between learning and working in the clinical area without being disheartened about doing "the right thing."

**Recommendation:**

Both students and clinical staff should be *briefed* on students' status in the clinical environment and learning in the psychomotor domain as a confluence of cognitive, affective and psychomotor learning. Such briefing and learning should be approached from an ethics and caring point of view.

**8.5.1.2 CATEGORY 2: Benefits of clinical learning experiences (Data display: 6.1.2)**

**Finding:**

Students perceive the clinical area as an area of "prime learning" involving reinforcement of knowledge, correlation of theory to practice and practice to theory.

**Conclusion:**

Students appear to have realised the key importance of clinical experience as they show awareness of the key values in clinical experiences.

**Recommendation:**

In order to strengthen and ensure that the clinical field remains an area of "prime learning," student and clinical staff's awareness should be directed towards the importance of maintaining:

- Quality patient care
- Professional and collegial relationships
- Student interest in the clinical area
- A therapeutic and educational milieu.

In addition to students nurse understanding their status in the clinicalfield, clinical staff should be aware of student nurses' "status" with regards to:

- Outcomes to be attained while in the clinical area
- Level of advancement of students
- Theoretical content of the curriculum

An in-service education programmes should be developed to address these themes.

### **8.5.1.3 CATEGORY 3: Student nurses' expectations (Data display: 6.1.3)**

#### **Finding:**

Students' expectations cover a wide range of expectations including expectations they have about themselves (their abilities and capabilities | attaining set outcomes in relation to their level of advancement); expectation about clinical facilitators and clinical staff relating to their person, their ability and willingness to guide students and to be involved in student learning and the dynamics in the clinical area); and the type of experiences to be gain including workload.

#### **Conclusion:**

Students' expectations are positive and negative, realistic and unrealistic as well as founded and unfounded. Expectations students have about aspects relating to the clinical field exerts considerable influence on their motivation, involvement in and commitment to learning in the clinical field. It is thus vital that both students and significant others in the clinical field understand students' expectations.

#### **Recommendation:**

With regard to student self-expectations, such expectations should be identified prior to clinical placements, and should be discussed with students in order to prevent students from entering the clinical field with unrealistic expectations running the risk of being disillusioned. On the other hand, realistic expectations should also be strengthened, to serve as an internal source of motivation. Individual interviews with students, briefing session individually and in groups and personal values clarification sessions with students can be implemented.

With regards to clinical facilitators, clinical educators and clinical staff, students should be provided with an outline of the role of these individuals regarding accompaniment

and guidance of students in the clinical field. Students should not be totally disconnected from their expectations, but should be brought to realistic awareness through orientation and continued evaluation of expectations during their clinical exposures.

#### **8.5.1.4 CATEGORY 4: Teaching strategies emerging from the clinical field (Data display: 6.1.4)**

##### **Finding:**

Participants indicated a variety of teaching strategies that emerge from the clinical field. These strategies cover cognitive and psychomotor learning and involve peers, clinical staff, one on one teaching and group teaching strategies. Learning in the affective domain is not well covered by these strategies.

##### **Conclusion:**

Students do not seem to be aware of, or having experienced, life skills training and personal asset assessment training or self-awareness strategies in the clinical field.

##### **Recommendation:**

In line with *awareness* as the central all encompassing concept for the current study, strategies creating self-awareness, such as values clarification, reflective practice and mindfulness are recommended. In addition, life skills training including assertiveness training, meaning attribution training, appreciation training including aesthetic training and involvement and personal asset assessment training are recommended.

#### **8.5.1.5 CATEGORY 5: What is learned (Data display: 6.1.5)**

What is learned in the clinical field relates directly to creating an integrated holistic awareness within students. For this reason sub-categories are dealt with individually in this section.

#### **8.5.1.5.1 *The dynamics of the clinical field (Data display 6.1.5.1) and interacting and connecting (Data display 6.1.5.5)***

##### **Finding:**

Aspects such as continuity in the clinical field, becoming a team member, interpersonal relationships and dealing with ambiguity and uncertainty in the clinical field all imply the dynamic nature of the clinical field. All of these have some influence on student involvement, connectedness and interactions in the clinical field.

##### **Conclusion:**

Student nurses need to be prepared to deal with the dynamics of the clinical field. Becoming a team member pertinently points towards an enhanced awareness of the student nurse in the clinical field; a preview of her future professional self. Hierarchical status in the clinical field often disrupts student connection and interaction. Breaking these down without sacrificing professional authority and discipline might lead to more open work relationships aiding students in dealing with ambiguities and ensuring continuity of learning in the clinical field.

##### **Recommendation:**

Clinical staff should, with regard to caring, practise what they preach. The caring ethic should become visible in student nurse education and training and learning in the clinical field as well. Colleges, campuses and hospitals should embrace the caring ethic which fundamentally states that caring entails allowing others (and self) to grow (Mayeroff 1971:1) and also that “kindness” is not caring.

Negative competition amongst different categories of clinical staff, retaliation and general negative relationships and attitudes need to be prevented by implementing a philosophy of a predominantly *learning* milieu within the clinical field.

#### **8.5.1.5.2 *Nursing ethics, professionalism and etiquette (Data display 6.1.5.3) and caring (Data display 6.1.5.4)***

##### **Finding:**

Students are aware of the importance to learn aspects of nursing ethics, professionalism, etiquette and caring first hand during their clinical experience.

**Conclusion:**

The clinical field needs to portray all aspects of nurse professionalism, nursing ethics, etiquette and caring as these are central to the profession of nursing. However, these are not always evident from participants' remarks or in the clinical field as personally experienced by the researcher. "Special days" and "events" to promote aspects of nursing professionalism and ethics, laudable as the intensions of these might be, are also a non-professional backhand to the profession as the topics of such days and events are supposed to be part of the everyday practice of nurses.

**Recommendation:**

A concerted effort should be made by services and education for all members of the health team to always demonstrate an outward image of professionalism and ethical perfectionism; in both private and professional spheres; in both routine and emergency situations. Professionalism must be lived. This calls for true **education** of nurses.

**8.5.1.5.3 Self-directedness (Data display 6.1.5.7), perseverance (Data display 6.1.5.8) and self-knowledge (Data display 6.1.5.9)****Finding:**

Directly relating to an integrated holistic awareness is students' experience that they learn more about themselves; about self-directedness, perseverance and self-knowledge in the clinical field.

**Conclusion:**

Students do experience a sense of self and the professional self in the clinical field, however, this is not really capitalised upon through the implementation of support systems and teaching strategies.

**Recommendation:**

What was stated under 8.5.1.4 is reiterated at this point. In line with *awareness* as the central all encompassing concept for the current study, strategies creating self-awareness, such as values clarification, reflective practice and mindfulness are recommended. In addition, life skills training including assertiveness training, meaning

attribution training, appreciation training including aesthetic training and involvement and personal asset assessment training are recommended.

#### **8.5.1.6 CATEGORY 6: Sources and resources of knowledge and skills (Data display: 6.1.6)**

##### **Finding:**

Students identified peers, clinical staff and educators as learning sources and resources. In addition, outcomes set to be attained during clinical allocation were identified as a learning resource. Most important, however, are students' perceptions of clients as learning sources and resources. In this regard, participants acknowledged aspects such as the informed client, client attitudes and the importance of maintaining good relationships with clients.

##### **Conclusion:**

The latter finding is also important in view of quality care and professional ethics, indicating the close relationship between quality learning and quality nursing practice in the clinical field. The importance of outlines of outcomes to be attained relates directly to answering the question: "Where am I?" with regard to professional development and student's integrated holistic awareness of self in the clinical field. Good student nurse patient relationships need to be fostered in addition to good relationships maintained with clinical and teaching staff. Students need to be supplied with clear guidelines as to what outcomes to attain during their clinical placements.

##### **Recommendation:**

The educational milieu to be established in all clinical areas includes a two pronged policy regarding students and patients, namely: 1) informing students how to maintain good relationships with patients; and 2) informing patients about the training that is being done in a clinical field and how patients can contribute towards this end.

Students must at all times be equipped with a workbook (clinical register) in which experiences leading to attaining stated outcomes are entered as "witnessed", "demonstrated" and/or as having reached the minimum requirements to attain the set outcomes.

In addition, all clinical staff should at all times be aware of the level of academic advancement of students so that they can optimally serve as a knowledge and skill resource in the clinical field. The outcomes set for students during clinical placements need to be discussed with clinical staff (practice and teaching staff) in detail. The educational task of each professional nurse and other sub-categories of nurses and health care professionals need to be re-emphasised and need to be included in all job descriptions. Clinical staff needs to emphasise the importance of the teachable moment; how to identify these moments and how to involve students in these opportunities.

## **8.5.2 Theme 2: The nature of lived experience of student nurses**

### **8.5.2.1 Positive experiences (Data display series 6.2.2)**

#### **Finding:**

Students' positive experiences relate to students themselves maintaining positive attitudes; experiencing joy in the form of hopefulness, overcoming adversary in the clinical field, experiencing personal growth and success and being accepted and feeling that they belong in the clinical field, as well as experiencing a sense of awareness, including self-awareness, awareness of what is to be known, awareness of nursing, and awareness of the clinical field as learning field.

#### **Conclusion:**

These findings are all fundamental to the central concept of *awareness* that accounts for, and accommodates all, themes, categories and data units that emerged from the data (See chapter 7). Awareness posits "being-in-the-world-with-others." Experiencing self through joy, hopefulness, growth and the like are all (including negative experiences as discussed in the next section) necessary to know self, a prerequisite for awareness. Such experiences are also fundamental to present self in an authentic manner and to experience the clinical environment authentically; in an integrated holistic manner with intrapersonal, inter-personal and extra-personal dimensions to awareness.

#### **Recommendation:**

It is recommended that integrated holistic awareness in all its dimensions be fostered in individual students.

With regards to the intra-personal and intra-psychic spheres it is recommended that students be guided to know themselves with regards to their reactions to, and biases and preferences regarding different clinical areas. Students need to be guided through values clarification sessions on different aspects relating to the clinical field. Story telling, personal narratives, positive imagining and personal analogies might also be considered. Briefing and debriefing sessions are important to maintain mental health of students in the clinical area. Reflective practice should be inculcated as a manner of routine practice as well as mindfulness. Life skills projected onto the clinical arena should form part of the curriculum. In the latter instance, assertiveness training for students directed toward empowerment of students should be considered as well as the assessment of personal assets of students made by themselves (Ebersöhm & Eloff 2003).

With regard to the intra-personal domain, students and clinical staff should be equally informed about the level of advancement of students and the position of the student in the clinical area. Students should understand that working in the clinical area should lead towards learning and clinical staff members need to understand that students are in the clinical area first and foremost to learn. Services and education need to cooperate with regard to all aspects of students' clinical placements. Services need to be cognisant of the clinical outcomes set for different levels of advancement of students. A total learning milieu needs to be created and maintained in clinical fields to which students are allocated for clinical learning. The negative elements of the power differential that may exist between qualified clinical staff and students need to be equalised and needs to be balanced with elements from professional practice, authority, respect, trust and discipline. Professional role modeling by qualified personnel reflecting skillfulness, knowledgeable, positive attitudes and ethical conduct is of the utmost importance. Basic nursing etiquette needs to be reinstalled where necessary.

With regard to the curriculum, all the above need to be included as curriculum contents. Chosen learning theories should be applied in a manner that illuminates personal awareness (as discussed in chapter 7). Teaching strategies should also be focused on creating and advancing an integrated holistic awareness within and among students and clinical staff. Finally, the curriculum should depart from a philosophical base such as existentialism, phenomenology and humanism that emphasises awareness.

### 8.5.2.2 Negative experiences (Data display series 6.2.3)

#### **Finding:**

Students experience negative experiences in the clinical field including feeling isolated, demoralised, frustrated, frightened and negated. In addition, students often found themselves “lingering” in situations they experienced as incidences of “non-learning.”

#### **Conclusion:**

These negative experiences by students are counterproductive to creating a positive integrated holistic awareness of self in the clinical arena and these affect the quality of the student nurses’ experiences impacting negatively on learning. These may even be harmful to students’ self-concept. With regards to “lingering” the question remains as to students’ initiative to involve themselves in whatever activities they find worth doing. It might be that their perception of “non-learning” influences their decision to *linger* rather than to participate in whatever there is to be done in the clinical field. Both students and clinical staff should realise that there is really no instance of “non-learning” or no learning. Whatever one does, and regularly so, is bound to become habitual, implying that learning occurs.

#### **Recommendations:**

In addition to the recommendations on the creation of a total learning milieu in the clinical area where students are placed for practica, most of the negative experiences reported by students, call for *invitational* education.

In-depth analyses of students’ attitudes towards the clinical field as learning field need to be conducted. Evaluation reports in the form of diaries and formal reports need to be obtained from students on completion of specific periods of allocation to the clinical field. Such reports need to be discussed with students and others implicated (both positively and negatively) in such reports. This calls for trusting relationships in the clinical area, something which does not always exist between students and clinical staff. In this regard, caring which the nursing profession professes to, should be operationalised in educational terms. Fundamentally, personal growth within the clinical learning milieu should be projected on all involved, student and clinical and teaching staff alike.

In addition, clinical facilitators need to understand the uniqueness of student nurses; establish good student-registered nurse rapport by encouraging student nurses to openly express their feelings; develop empathetic listening skill to understand how student nurses experience their learning and teaching; and correct student nurses' misconceptions and perceptions about the clinical area. Student nurses should be provided with information to empower them.

### **8.5.3 Theme 3: Motivational factors**

Factors that enhance motivation in the clinical learning field involve praising students, the availability of nurse educators in the clinical field and cooperative learning. The latter is supported by students' references to the importance of information exchange, problem-solving, practicing procedures, self-evaluation and peer evaluation and discussion groups.

#### **Conclusion:**

All the factors contributing positively towards student learning in the clinical field also contribute positively towards an integrated holistic awareness within students. Intra-personal and inter-personal elements are strongly represented by the categories contained in the theme on motivational factors. Cooperative learning can be used to encourage cooperation in general in the clinical field, counteract negative competition, enhance individual students' self-esteem, develop collaborative skills, and promote support systems in the clinical field. Cooperation is a basic professional skill that can only be fully mastered in the clinical field.

#### **Recommendations:**

Teaching and management strategies that will accommodate individual participation in the education and practice of students by students need to be implemented. Developing a general learning climate or milieu within the clinical field is imperative. Cooperative learning should be initiated from educational circles and should not be a last desperate attempt by students themselves to initiate learning in the clinical area. Invitational learning, education and services cooperation and student self-knowledge all from a firm base on which cooperative learning could be based.

#### **8.5.4 Theme 4: Erosive factors in clinical learning**

##### **Finding:**

In addition to students' negative experiences in the clinical field, factors that can erode learning in the clinical field that emerged from the data involve hostility, lack of responsibility, negative perception students have of clinical staff, retaliation and student status. In all instances students, as well as clinical and teaching staff may be implicated.

##### **Conclusion:**

These erosive factors due to their emotive nature can have negative implications for student connectedness and an integrated holistic awareness in the clinical learning field. Though peer solidarity could be a positive aspect in cooperative learning, ganging up on the part of students or any other negative form of *solidarity* should be prevented and counteracted. With regard to students' status, lack of understanding of student nurses' responsibilities by clinical facilitators may cause increased dissonance rather than provide the needed support for the troubled student nurses.

##### **Recommendation:**

The importance of a total learning milieu within the clinical learning field is reiterated. Good interpersonal relationships, management strategies that promote student empowerment and equalisation of established power differentials, educational strategies that provide for student participation and generally high quality nursing care and quality learning experiences for students are all applicable and recommended to counteract the erosive factors mentioned by students.

#### **8.6 RECOMMENDATIONS REGARDING FUTURE RESEARCH**

The findings of the present research indicate a number of areas of student learning and teaching in the clinical field that deserve in-depth research. A number of topics that need to be investigated relate to:

- students' perceptions of their position within the hierarchical structure in the clinical field
- clinical staff's perceptions of student clinical teaching as part of their job description and professional responsibility

- student empowerment in the clinical area
- socialisation of students in clinical areas with less than satisfactory human and material resources
- the impact of the clinical environment on student learning
- the expectations of student nurses versus the actuality of clinical environments and learning
- the impact of (negative) solidarity among students while being in the clinical field
- emotional support systems available for students in the clinical field
- enhancement of emotional intelligence through student empowerment in the clinical field
- action research into the creation of a total learning milieu within the clinical field based on the guidelines provided in section 8.8.

## **8.7 RECOMMENDATION REGARDING THEORY DEVELOPMENT**

In line with the general aim of qualitative research regarding theory development, it is recommended that:

- The concept of *integrated holistic awareness* in the clinical field be further explicated as a multidimensional concept and that a model be developed for enhancing such awareness among student nurses, clinical staff and teaching staff; a total education and services integrating model placing the student nurse in the centre.

## **8.8 GUIDELINES FOR PROMOTING LEARNING THROUGH ESTABLISHING INTEGRATED HOLISTIC AWARENESS WITHIN THE CLINICAL FIELD AS LEARNING FIELD**

### **8.8.1 Nursing education**

The curriculum in its totality needs to focus on enhancing the student's perception and awareness of her career position at any point in time.

### **8.8.1.1 Curriculum philosophy**

Base the curriculum on a philosophical base that provides for *awareness* and that reflects awareness in its basic tenets such as in

- Existential philosophy
- Humanistic philosophy
- Phenomenological philosophy

### **8.8.1.2 Teaching strategies**

Teaching strategies should provide for student participation, multi-sensory integration and socialisation within a total learning milieu through:

- Invitational learning.
- Balancing principles of andragogics with those of pedagogics.
- Balancing principles of receptive learning with those of discovery learning.
- Implementing strategies that will enhance self knowledge of students such as reflective practice, values clarification, mindfulness and personal asset assessment.
- Implementation of strategies that will promote socialisation such as discussion groups and socio-drama involving all levels of staff in the clinical field.
- Maximising the utilisation of the teachable moment in addition to formal experiences to enhance multi-sensory integration and problem solving.
- Allowing for formal briefing and debriefing sessions with students including self-appraisal and asset assessments of themselves by students.
- Problem-solving, creative thinking, critical thinking and decision-making exercises, both theoretical and from the clinical practice standpoints.

### **8.8.1.3 Curriculum contents**

In addition to regulatory stipulations on curricular content, in an attempt to foster *integrated holistic awareness* in and among students, and a sense of connectedness and belonging in the clinical field, curriculum contents must provide for:

- Emotional and social intelligence in addition to cognitive intelligence.
- Meta cognition and an understanding of learning.
- The integration and understanding of the affective, cognitive and psychomotor domains of learning.
- Life skills training including assertiveness training and personal asset assessment.

#### **8.8.1.4 Assessment and evaluation**

Continuous assessment needs to be conducted on the following:

- Attainment of objectives set for students while allocated to a specific clinical area using workbooks and clinical registers.
- Students' perception of their *presence* in the clinical area.
- Students' experiences in the clinical field with special emphasis on possible negative experiences.
- Relationships of student with peers, superiors and patients.
- General conduct of students in the clinical field.
- Briefing and debriefing sessions.
- Reflective practice.
- Self-evaluation of students of the value of their experience in a specific clinical field.
- Comprehensive reality assessment of students involving all the domains of learning as well as all stakeholders in the clinical field (clinical and teaching staff as well as patients/clients).
- Critical analysis of any given situation.

#### **8.8.2 Services**

Several aspects relating to management in general could attribute towards creating an integrated holistic awareness regarding students' position in the clinical field. These relate to the following:

- Commitment to education for service and service for education; creating a total learning milieu within the clinical field.
- Embracing a caring philosophy as foundational to management. All management principles need to be redefined in terms of the caring philosophy.
- Founding management on principles of existential, humanistic and phenomenological philosophy.
- Including teaching as foundational to the job description of all categories of staff.
- Preparing all categories of staff via in service training for clinical teaching with special reference to the teachable moment.
- Equalising the power differential that exists in the clinical area without sacrificing discipline.
- Promote professional conduct and appearance among staff.
- Students to be treated as becoming professionals.
- Regular audits of clinical learning environments to identify whether standards are in line with the educational program of student nurses and whether resources for learning, both material and human, are adequate.
- Quality assurance should also be in place to address clinical patient care, for example, to minimize incidences of students learn from mistakes.
- Identify performance plans of student nurses within clinical learning environments.
- Compile improvement plans emanating from student nurses complaints to prevent repetitions of negative experiences and erosive factors.
- Conduct student satisfaction surveys and improvement plans.
- Conduct clinical nurses' satisfaction surveys with student nurses' learning in these respective clinical areas.
- Bench making best practices to other provinces for improvement purposes.

### **8.8.3 Cooperation between services and education**

To ensure improvement in learning of student nurses, joint planning between services and education needs to be done regarding:

- Formulation of outcomes for specific clinical fields.
- Placement of student nurses in clinical learning environments.
- Policy on the availability of clinical facilitators.
- The role of clinical staff in student education and training.
- Access of clinical tutors and college staff to clinical facilities and the clinical field.
- Practical sessions for college staff in the clinical area.

#### **8.8.4 Clinical area**

##### **8.8.4.1 Orientation of clinical facilitators**

In an attempt at enhancing clinical learning and ultimately an integrated holistic clinical awareness clinical facilitators need to be orientated towards

- enhancement of their understanding of the different programmes student nurses follow
- the allocation of student nurses to their areas of authority with regard to students' levels of advancement and learning outcomes to be attained
- formulating outcomes for students in specific clinical areas
- identify and involving members of the clinical staff with specific skills and knowledge in the clinical learning of students
- training clinical staff to serve as effective change agents
- utilizing the teachable moment

##### **8.8.4.2 Nursing practice**

As quality nursing care and practice ensure quality student learning experiences in the clinical field, clinical practice should

- reflect the highest standard of professional and ethical conduct
- professional role modelling should be a life way of all levels and categories of clinical and teaching staff
- institutional philosophy, values, mission and vision should be *lived* by all involved in the clinical setting including students

- quality assurance committees should be established, and should be functional and operational

## 8.9 EVALUATION OF THE STUDY

The researcher's scientific and professional integrity compels her to acknowledge both positive (significant) and negative (limitations) aspects relating to the current study.

### 8.9.1 Positive outcomes

The following are positive outcomes of the current study:

- The phenomenon, lived experience of student nurses of the clinical field as learning field, was studied in a real life context.
- Authentic information and data were generated during the study.
- The results in this study unveiled areas for further research studies.
- The concept of "integrated holistic awareness" in the clinical field allows for the construction of a model that could direct clinical learning and the organisation of clinical learning in such a way that the most intense possible professional socialisation of students into the profession of nursing could be attained. This concept, however, still needs to be explicated in more detail and needs to be refined through continued research.
- The concept of "integrated holistic awareness" is fundamental to being a human being and is, as such, a concept that might be *generalised* as important to all student nurses and clinicians in all clinical fields.

### 8.9.2 Limitations

This research was subject to a number of limitations, namely:

- Due to the type of design utilised for the study, the study included a limited number of participants which infringes on the *generalisability* of findings.
- Time constraints had a negative influence on the study as the central all encompassing concept of "integrated holistic awareness" (and connectedness of students) had not been explicated fully

- Furthermore, although this qualitative paradigm yielded fundamental insights into subjective experiences of students in clinical learning, the strength of the future research into emergent themes from the current research might be best conducted using both qualitative and quantitative methods as well as a larger and more representative sample size.

### **8.9.3 The researcher's experiences during the current study**

Conducting a phenomenological study into the lived experience of student nurses in the clinical field as learning field, was a major learning curve for the researcher at both the methodological and the empirical (ontological) level. The researcher came to realise the importance of language in constructing a life world and in constructing knowledge. That much more has happened than what is said and that much more is said than is initially heard. The researcher can thus full heartedly profess:

*“Never lose an opportunity of urging a  
practical beginning, however small,  
for it is wonderful how often the mustard  
seed germinates and roots itself”*

*Florence Nightingale*

(Waddell & Bauer 2005:6)

The topic for the current research developed out of both an interest in and a concern about, the experiences of student nurses in the clinical field. Although the researcher was certain that the study would be conducted in the qualitative paradigm, the relationship between the research topic, the research question and the methodology was not clear to her. This led to a feeling of despair during the early stages of the research. During the development of a proposal, the researcher asked herself time and time again how the research that she was going to conduct might be understood in terms of phenomenology. This became clear after the researcher was advised to review the literature on phenomenology prior to constructing a research proposal and to submit the scientific essay on phenomenology, both as a philosophy and a methodology. While reading about phenomenology as both a philosophy and a methodology the researcher became very discouraged thinking that maybe she has chosen a topic that might not be researchable. However, this essay enabled the researcher to re-think the possible

scope and role of phenomenological research within clinical field. It also provided the researcher with insight into the subject-object relationship, the basic of the philosophy of science and qualitative research and the options open to her in conducting a phenomenological study. The researcher then became aware as to how the phenomenology of lived experience relates to the any domain of life experience including the lived experience of “being-in-the-clinical-field.”

A major challenge of the current phenomenological study was arranging and conducting face-to-face interviews with participants. The researcher had to exercise patience during in-depth interviews as phenomenological research requires that the researcher stands in the fullness of life, in the midst of the world of living relations and shared situations with participants. As interviews progressed the research became more and more involved in the lives and experiences of the participants. As follow-up interviews progressed, some participants developed higher levels of openness and preparedness to share their experiences with the researcher. As a result these shared experiences became a reminder of the researcher’s own experience as a student nurse. These recollections were, however, kept in abeyance during probing and data analysis.

The researcher experienced further difficulty in applying Wertz’s (1983, 1984, 1985) idiographic and nomothetic levels of data analysis. Continued rereading of Wertz’s approach to data analysis eventually became fruitful. As the data analysis advanced the researcher experienced that it was easier said than done to thrust aside categories as these were the researcher’s own constructions. It was like disposing of something dear to oneself. And, whatever students said, was said under guidance, or in relation to, the research question.

## **8.10 CONCLUSION**

In this chapter, an overview of the research process is given. Findings are summarised and conclusions are drawn from these accompanied by recommendations. Recommendations pertain to the fields of education, service and clinical practice. The concept of *integrated holistic awareness* highlights some of the conclusions and recommendations.

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## Appendix A

PO Box 1712  
Letaba  
0870  
14-05-2003

The Head of Department  
Department of Health and Welfare  
Private Bag  
LIMPOPO

Dear Madam/Sir

### **PERMISSION TO CONDUCT RESEARCH**

#### **DOCTORAL STUDY: LIVED EXPERIENCES OF STUDENT NURSES ON CLINICAL FIELD AS LEARNING EXPERIENCES IN LIMPOPO PROVINCE: MONGWE RN (IMPLICATIONS FOR STUDENT NURSES)**

I am a student at the University of South Africa doing my Degree in Doctor of literature and philosophy.

The aim of the study is to gain an empirically based understanding of the experiences of student nurses during the clinical facilitation and learning within the clinical learning field, as well as to develop the empirical based understanding theory and guidelines to improve clinical learning and facilitation.

May I please be granted permission to collect necessary data from the student nurses? I would also like to request permission to perform a pilot study.

A copy of provincial permission is therefore attached.

Yours faithfully

**RN MONGWE (MRS)**

## Appendix C

PO Box 1712  
Letaba  
0870  
26-12-2003

Dear Student

I hereby wish to inform you that I am doing research about I am a student at the University of South Africa doing my Degree in Doctor of literature and philosophy.

The aim of the study is to gain an empirically based understanding of the experiences of student nurses during the clinical facilitation and learning within the clinical learning field, as well as to develop the empirical based understanding theory and guidelines to improve clinical learning and facilitation.

I wish to request your contribution in this regard.

You will be invited to participate in an interview in this regard. I therefore assure you that the discussed information will be kept confidential.

If you are interested in participating please read and sign the attached agreement.

Your contribution in this regard will be highly appreciated.

Yours faithfully

**RN MONGWE (MRS)**

**Consent form**

**Agreement**

I,..... on this ..... day of ..... 200 ... hereby give consent to:

Being interviewed by R N MONGWE on the topic “*The lived experiences of clinical facilitation by student nurses within clinical learning environments in Limpopo Province.*”

- Follow-up interviews if necessary.
- The interviews being audiotaped.
- The use of data derived from these interviews and follow-up interviews by the interviewer in a research report as deems appropriate.

I also understand that:

- I am free to end my involvement or to recall my consent to participate in this research at any time I feel like it.
- Information given up to the point of my termination of interviews could however still be used by the researcher.
- The researcher grants anonymity and that will under no circumstances be reported in such a way as to reveal my identity.
- More than one interview might be necessary.
- No reimbursement will be made by the researcher for information given or my participation in this project.
- I may refrain from answering questions should I feel these are an invasion of my privacy.
- By signing this agreement I undertake to give honest answers to reasonable questions and not to mislead the researcher.
- I will be given the original copy of this agreement on signing this agreement.

I hereby admit the truth that the researcher explained the aims of this research project with me. I was informed about the content of this agreement as well as the essence of signing this agreement.

In co-signing this agreement the researcher undertakes to:

- Maintaining confidentiality, anonymity, and privacy regarding the interviewee’s identity and information given by the interviewee.
- Arrange in advance a suitable time and place for an interview to take place.
- Safeguard the duplicate of this agreement

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**(Interviewee)**

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**(Interviewer)**

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**(Date)**

## Appendix D

### IN-DEPTH PHENOMENOLOGICAL INTERVIEW | SCHEDULE FOLLOWED IN INTERVIEWING STUDENT NURSES IN “*THE LIVED EXPERIENCES OF CLINICAL FACILITATION BY STUDENT NURSES WITHIN CLINICAL LEARNING ENVIRONMENTS IN LIMPOPO PROVINCE*”

#### SECTION 1

##### 1.1 CHECKLIST FOR IN-DEPTH PHENOMENOLOGICAL INTERVIEW

###### Advance Notice

- ✓ Contact participants by phone two weeks before the session.
- ✓ Send each participant a letter of invitation.
- ✓ Give the participants a reminder phone call prior to the session.
- ✓ Make arrangement for the venue through the Head of College campus.
- ✓ The introductory question should be answered quickly.
- ✓ Key question should focus on the critical issues of concern.
- ✓ Use considered probes or follow-up questions.
- ✓ Limit the use of “why” questions.

###### Logistics

- ✓ The room should be appropriate (size, tables, comfort, and so on).
- ✓ Background noise should be eliminated.
- ✓ Bring extra tapes, batteries, and extension cords.
- ✓ Plan topics for small talk conversation.

###### Interviewer skills

- ✓ Be well rested and alert for the in-depth phenomenological interview session.
- ✓ Practice introduction without referring to notes.
- ✓ Memorise question without referring to notes.
- ✓ Avoid signal approval.
- ✓ Avoid personal opinions.

### **Immediately after the session**

- ✓ Prepare a brief written summary of key points as soon as possible.
- ✓ Check to see if the tape recorder captured the comments.

## **1.2 OBJECTIVES**

### **1.8 RESEARCH OBJECTIVES**

The research objectives of this study are as to:

- explore the question, what is the lived experience of the clinical learning environment as learning experiences?
- discover a truthful picture of experiences of student nurses at second, third and fourth level regarding the experiences of clinical learning environment as learning experience;
- describe the experience of student nurses of the clinical learning environments as the learning experience to come up with theory about these experiences as well as guidelines to improve clinical facilitation and learning; and
- understand more fully the structure, and meaning of student nurses' experience and relate that lived event as it is immediately experienced.

### **1.3 INTRODUCTION**

**Confidentiality will be maintained regarding all information sessions. No names will be documented during the recording of information.**

**Welcome:** Good morning and welcome to our session today. Thank you for taking the time to join our discussion to share your experiences of clinical facilitation and learning in the clinical field. My name is Norah Mongwe. I am a Doctoral student at the University of South Africa. I am particularly interested in your lived experiences in the clinical field.

Please feel free to share your point of view,

**Ground rules:** Before we begin, let me remind you of some ground rules.

- This is strictly a research projects. The information will not be used against you.
- I will be tape-recording the session, because I don't want to miss any of your comments.
- I will use our first names today. In the later reports there will not be any names attached to comments. You may be assured of complete confidentiality.
- Keep in mind that I am interested in all comments both positive and negative as they constitute your experiences.
- The session will last an hour and I will not be taking a formal break.
- Feel free to leave the table for if you wish to stretch.
- Finally, please say exactly what you have experience.

## **SECTION 2**

### **STUDENT NURSES' INTERVIEW QUESTION**

#### **1 INTRODUCTION**

**1.1** Please briefly tell me about yourself and the last time you were allocated in the clinical field?

#### **2 Research Question**

How do you experience clinical learning environment as learning experience?

#### **3 PROBES GUIDED BY THE RESPONSES**

## **CONCLUSION**

Immediately after the session

Give a brief written summary of key points as soon as possible.

Check to see if the tape recorder captured the comments.

## Appendix D

### Sampling questionnaire

This questionnaire will enable you to be selected as an informant on in-depth phenomenological interview of experiences of student nurses during the clinical facilitation and learning within the clinical learning field by the researcher.

Personal information is needed, in order to contact you if you are needed if you are selected to participate in this study.

May you please supply us with the necessary information?

Name.....

Surname.....

Clinical unit.....

Phone.....

Experience in clinical exposure.....

I acknowledge that the content of this questionnaire was explained to me, as well as the purpose, which the results will serve ..... (PARTICIPANT)

I, RN MONGWE hereby undertake to uphold the anonymity of the respondents ..... (RESEARCHER)

## Appendix A

PO Box 1712  
Letaba  
0870  
Date?????????

Ms/Mr .....

Deur Sir/Madam

Thank you for accepting the invitation to attend the discussion, which will take place in the library of the College Campus. The meeting will be on Wednesday, November, from 9:00. Date????

Since we are talking to a limited number of people, the success and quality of our discussion is based on the cooperation of the people who attend. Your attendance at the session will aid in making the research project a success.

The discussion you will be attending will deal with the teaching of student nurses in the clinical area. We would like to get your opinions and views on this subject.

If for some reason, you find that you will not be able to attend, please contact either of these numbers: 013-795 5000 ext 2285/6 or 0833384891

Thank you.

Yours faithfully

**RN MONGWE (MRS)**