PERCEPTIONS OF PUPIL NURSES AT THEIR SECOND YEAR LEVEL TOWARDS CLINICAL SUPPORT AT A PRIVATE HOSPITAL IN THE LIMPOPO PROVINCE, SOUTH AFRICA

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DECLARATION

I declare that **PERCEPTIONS OF PUPIL NURSES AT THEIR SECOND YEAR LEVEL TOWARDS CLINICAL SUPPORT AT A PRIVATE HOSPITAL IN THE LIMPOPO PROVINCE, SOUTH AFRICA** is my own work and that all the 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 other institutions.

15 July 2016

(M Poto) **Date**

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ABSTRACT

The purpose of the study was to explore and describe the perceptions of the pupil nurses at their second year level towards clinical support at the private hospital in the Limpopo Province.

Qualitative approach including exploratory, descriptive and contextual study design was followed. The target population for this study included pupil nurses at their second year level (n=20) following a two year programme leading to enrolment as a nurse from a private nursing education institution in the Limpopo Province. Data was collected utilizing written narratives, and focus group interviews. Field notes and audio tape were used to capture data. Data saturation was reached on twelve participants.

Data were thematically analysed using Tesch's method of open coding. The results revealed lack of clinical support. Lack of clinical support was attributed to inadequate educators for accompaniment, registered nurses' uncaring attitude and not fulfilling their mentorship role, and pressure on pupil nurses to meet the high clinical demands. Pupil nurses were found not to be assuming full responsibilities over their practical learning. Therefore, it is mandatory as nurse educators, managers and researchers to take note of the gaps identified and intervene utilising recommendations provided to enhance clinical support.

KEYWORDS

Perception; pupil nurse; clinical support; nurse educator; registered nurse.

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TABLE OF CONTENTS

CHAPTER 1 ..... **1**
ORIENTATION TO THE STUDY **1**
1.1 INTRODUCTION 1
1.2 BACKGROUND TO THE RESEARCH PROBLEM 2
1.3 STATEMENT OF THE RESEARCH PROBLEM 3
1.4 PURPOSE OF THIS STUDY 5
1.5 RESEARCH OBJECTIVES 5
1.6 RESEARCH QUESTION 6
1.7 SIGNIFICANCE OF THE STUDY 6
1.8 FRAME OF REFERENCE 6
1.8.1 Theoretical framework 7
1.8.2 Assumptions underlying the study 7
1.8.2.1 Ontological assumptions 7
1.8.2.2 Epistemological assumptions 8
1.8.2.3 Theoretical-conceptual assumptions 8
1.8.2.4 Methodological assumptions 9
1.9 DEFINITION OF KEY CONCEPTS 9
1.10 RESEARCH DESIGN AND METHODOLOGY 12
1.10.1 Research design 12
1.10.2 Research setting 12
1.11 RESEARCH METHODOLOGY 13
1.11.1 Population and sample 13
1.11.2 Data collection 14
1.11.3 Data analysis 14
1.11.4 Measures to ensure trustworthiness 15
1.11.5 Ethical considerations 15
1.12 OUTLINE OF THE STUDY 15
1.13 CONCLUSION 16
CHAPTER 2 ..... **17**
LITERATURE REVIEW **17**
2.1 INTRODUCTION 17
2.2 THE DEFINITION OF THE CONCEPTS CLINICAL environment, SUPPORT AND CLINICAL SUPPORT 17

2.2.1 The concept clinical environment 17
2.2.2 The concept support 18
2.2.3 The concept clinical support 18
2.3 THEORETICAL FRAMEWORK 19
2.3.1 Role theory 19
2.3.1.1 The functional perspective 21
2.3.1.1.1 The concept role 21
2.3.1.1.2 The concept status 21
2.3.1.1.3 The concept role performance 21
2.3.1.2 Symbolic interaction perspective 23
2.3.1.2.1 Implication for the symbolic interaction on clinical support 23
2.3.1.3 Socialisation for roles 24
2.4 ROLE PLAYERS IN THE PROVISION OF CLINICAL SUPPORT 25
2.4.1 The nurse educator 25
2.4.1.1 The scope and content of the nurse educator's clinical responsibilities towards clinical support 27
2.4.1.1.1 Clinical support through cognitive enhancement 27
2.4.1.1.2 Clinical support through enhancement of psychomotor domain 29
2.4.1.1.3 Clinical support through affective skill enhancement 30
2.4.1.2 Accompaniment role of the nurse educator 31
2.4.2 Mentors 32
2.4.3 Preceptorship 33
2.4.4 The registered nurse 34
2.4.4.1 Clinical supervision role of the registered nurse 35
2.4.5 The patient 35
2.4.6 The pupil nurses at their second year level 36
2.4.7 Clinical learning environment 36
2.4.7.1 The development of the learning environment 37
2.4.7.2 Involving multidisciplinary team members in the teaching at the nursing education institutions 38
2.4.8 SANC Position on clinical support as part of clinical teaching 38
2.4.8.1 Programme leading to enrolment as a nurse 38
2.4.8.1.1 Conditions for enrolment as a nurse 39
2.4.8.1.2 The nurse educators: key responsible people 39
2.4.8.1.3 The curriculum and the course content including the clinical training 40
2.5 GOALS OF CLINICAL SUPPORT 41
2.6 FACTORS HINDERING EFFECTIVE CLINICAL SUPPORT PROVISION 41
2.7 PROMOTION OF EFFECTIVE CLINICAL SUPPORT 41

2.8 CONCLUSION 42
CHAPTER 3 43
RESEARCH DESIGN AND METHODOLOGY 43
3.1 INTRODUCTION 43
3.2 RESEARCH DESIGNS 43
3.2.1 Qualitative approach paradigm 43
3.2.2 Exploratory design 45
3.2.3 Descriptive design 45
3.2.4 Contextual 46
3.3 RESEARCH METHODOLOGY 46
3.3.1 Population 46
3.3.1.1 The research setting 47
3.3.2 Sample and sampling 47
3.3.2.1 Inclusion criteria 48
3.3.3 Sample size 49
3.3.4 Data collection 49
3.3.4.1 Preparatory phase 50
3.3.4.1.1 Recruitment techniques and retention of research participants 50
3.3.4.1.2 Information to the participants 51
3.3.4.1.3 The exploratory interview 52
3.3.4.2 Data collection phase 53
3.3.4.2.1 Data collection methods 53
3.3.4.3 Post-interview phase 59
3.3.5 Data analysis 60
3.3.6 Ethical consideration 60
3.3.6.1 Approval 61
3.3.6.2 Permissions 61
3.3.6.3 Self-determination and informed consent 61
3.3.6.4 Privacy and confidentiality 62
3.3.6.5 Justice 62
3.3.6.6 Beneficence and non-maleficence 62
3.3.6.7 Measures to ensure trustworthiness 63
3.3.6.7.1 Credibility 63
3.3.6.7.2 Transferability 64
3.3.6.7.3 Dependability 64
3.3.6.7.4 Conformability 64
3.4 CONCLUSION 65

CHAPTER 4 66
RESULTS, INTERPRETATION AND DISCUSSION 66
4.1 INTRODUCTION 66
4.2 MANAGEMENT AND ANALYSIS OF DATA 66
4.3 FINDINGS OF THE STUDY 67
4.3.1 Demographic profile of participants 67
4.3.2 Themes and subthemes 68
4.3.3 Theme 1:1: Cognitive domain an integral part of theory practice integration 69
4.3.3.1 Subtheme 1.1: Knowledge related to the concept clinical support 69
4.3.3.2 Subtheme 1.2: Lack of cognitive support to enhance theory practice integration 72
4.3.4 Theme 2: Psychomotor domain enhance mastery of skills 73
4.3.4.1 Subtheme 2.1: Reflection on clinical skills performance 74
4.3.4.2 Subtheme 2.2: Uncertainties experienced during performance of patients' care activities 75
4.3.4.3 Subtheme 2.3: Clinical support: a team effort 76
4.3.4.4 Subtheme 2.4: Psychomotor support leads to realisation of goals 77
4.3.5 Theme 3: Clinical support not sustaining the caring phenomena 77
4.3.5.1 Subtheme 3.1: Provision of knowledge related to caring 78
4.3.5.2 Subtheme 3.2: Communication attributes in clinical support 78
4.3.5.3 Subtheme 3.3: Negative attitude versus positive attitude in clinical support 79
4.3.5.4 Subtheme 3.4: Clinical support apparently not sustaining confidence 80
4.3.5.5 Subtheme 3.5: Several adaptive mechanisms used by pupil nurses to learn and cope 80
4.3.6 Theme 4: Challenges encountered 81
4.3.6.1 Subtheme 4.1: Tales and personal distressing situations perceived related to clinical support 81
4.3.6.2 Subtheme 4.2: Support versus lack of support from the unit manager, mentors and nursing staff 83
4.3.6.3 Subtheme 4.3: Support versus lack of support from nurse educators 86
4.3.6.4 Subtheme 4.4: Resources utilised during clinical support 87
4.3.6.5 Subtheme 4.5: Allocated patients' activities not related to level of training 88
4.3.7 Theme 5: Self-directedness of pupil nurses 89
4.3.7.1 Subtheme 5.1: Setting own clinical learning goals and objectives 89
4.3.7.2 Subtheme 5.2: Taking responsibility to involve allocated mentors, tutors and ward staff members to teach 90
4.3.7.3 Subtheme 5.3: Support in management of time: a key element during clinical learning 91

4.3.7.4 Subtheme 5.4: Evaluation of outcomes 91
4.4 SIGNIFICANCE OF THE RESULTS 92
4.5 CONCLUSION 92
CHAPTER 5 94
RESEARCH FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY 94
5.1 INTRODUCTION 94
5.2 RESEARCH DESIGN AND METHOD 94
5.3 FINDINGS OF THE STUDY 95
5.4 RECOMMENDATIONS 106
5.4.1 Recommendations for the nursing education 107
5.4.2 Recommendations for the nursing management 108
5.4.3 Recommendations for the nursing research 109
5.5 LIMITATIONS OF THE STUDY 110
5.6 DISSEMINATION OF THE RESULTS 110
5.7 CONCLUSION 110

REFERENCES 111

ANNEXURES 121

ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE: UNIVERSITY OF SOUTH AFRICA, HEALTH STUDIES HIGHER DEGREES COMMITTEE 122
ANNEXURE B: REQUEST FOR PERMISSION TO CONDUCT STUDY AT PRIVATE HOSPITAL GROUP 123
ANNEXURE C: LETTER FROM THE PRIVATE HOSPITAL GROUP RESEARCH COMMITTEE TO THE PRIVATE HOSPITAL LIMPOPO PROVINCE 125
ANNEXURE D: LETTER OF INFORMATION TO PUPIL NURSES AT THEIR SECOND YEAR LEVEL 127
ANNEXURE E: INFORMED CONSENT 129
ANNEXURE F: CODING REPORT 130
ANNEXURE G: EDITING LETTER 132
ANNEXURE H: FOCUS GROUP INTERVIEW GUIDE – CENTRAL QUESTION 133
ANNEXURE I: EXAMPLE: THEMES AND SUB-THEMES 134

LIST OF TABLES

Table 4.1 Demographic profile of participants 67

Table 4.2 Themes and subthemes reflecting perceptions of the pupil nurses at their second year level towards clinical support during clinical placement at the private hospital in the Limpopo Province, South Africa 68

Table 5.1 Main themes 95

LIST OF ABBREVIATIONS

HEI	Higher Education Institution
NEI	Nursing Education Institution
NES	Nursing Education Stakeholders
NMC	Nursing and Midwifery Council
R	Regulation
SANC	South African Nursing Council
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Nursing education comprises of two components, namely: theory and practice. Theory is mainly classroom based while practice takes place in the clinical learning environment where affective and psychomotor domains are enhanced. This is supported by Anarado, Agu and Nwonu (2016:140) who stated that clinical training forms an integral part of professional nursing education as it equips the student with necessary knowledge, attitudes, skills and values required for optimal practice in real situations. The World Health Organization (WHO) (2001:77) affirms that "the performance of a health care systems rest ultimately on the knowledge, skills and motivation of people rendering the health care". Milton-Widely, Kenny, Parmenter and Hall (2013:648) highlighted that health systems in many countries are facing the same challenges of ensuring future supply of nurses that could render quality nursing care. It is further asserted in the study that this could be contributed by the fact that most of the nurses that are proficient in performing those skills are aging. The students expect support from key individuals within the clinical placement area to enable them to identify learning opportunities that can assist them to make sense of their practice so that they could reflect and be able to integrate theory into practice. The student`s expectations can be achieved through exposure to a supportive clinical learning environment where they are guided and supported to make connections between the knowledge of the nursing science acquired in the classroom and the application of the art needed in the real life situation in the clinical field (Hughes & Quinn 2013:368).

In South Africa, nurses are guided by the Scope of Practice that is outlined in R2598 of 30 November 1984 (R2598, 1984, Paragraph 6) which states that the competencies that are expected from more junior nurses including student nurses, needs to be practiced under the direct and indirect supervision of a registered nurse. The regulation further stipulates that all nurse practitioners should conduct their practice on a scientific base. It is therefore mandatory that all nurse practitioners be exposed to continuous professional development so that they could be able to help the students to integrate

theory into practice. According to Bruce, Klopper and Mellish (2011:253), the clinical learning environment provides learning opportunities for student nurses to learn from their exposure with patients, clients, family as well as the communities to integrate theory and practice. In addition, Bruce et al (2011:254) further assert that aims of clinical education is to produce an independent nurse practitioner who is capable of utilising acquired knowledge to make important decisions when practising the art of nursing. Kaphagawani and Useh (2013:184) highlighted factors influencing integration of theory into practice being clinical educator and nursing staff technical competency skills gap, as well as non-conducive clinical learning environment.

In this study, the researcher adopted a qualitative, descriptive, exploratory and contextual research approach to explore and describe the perceptions of pupil nurses at their second year level towards clinical support during placement at one private hospital of the Limpopo Province, South Africa.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

In South Africa, there are presently three basic categories of nurses in training, namely; registered nurses, enrolled nurses and enrolled nursing auxiliaries (South Africa 2005:25). The South African Nursing Council (SANC) is the responsible body for accrediting nurse training providers in both the private and public sector. Pupil nurses complete a two-year certificate programme, guided by the SANC (R2175, 1993, as amended) (SANC 1993b) and this category of nurses, upon qualification are called enrolled nurses, who works under direct and indirect supervision of registered nurses. According to R2175, 1993, as amended (SANC 1993b), the main aim of their curriculum is the acquisition of skills and knowledge to enable them to render basic nursing care. The pupil nurses are expected as stipulated in terms of SANC (1993b:1, 3(a), 5) to spend over 2000 clinical training hours over two academic years to meet the practical requirements to become enrolled nurses who will be able to function under direct or indirect supervision of a registered nurse. SANC (R2598, 1984, as amended) outlines the scope of practice of registered nurses being “the co-ordination of the health care regimens provided for the patient by other categories of health personnel.” Therefore, it is important that during clinical placement the registered nurses, including the nurse educators as well as the unit managers should facilitate the integration of theory into practice, whereby the students are taught nursing skills, supervised, supported, and

assessed to evaluate their overall performance and readiness in becoming competent practitioners.

Pupil nurses at their second year level from a private nursing institution in the Limpopo Province are placed at a private hospital for the fulfilment of their practical component. This is first and foremost the responsibility of the nurse educator and secondly the registered nurses in the units. However, Davis and Sondlo (2016:31) state that although registered nurses are aware of their teaching role they are still faced with numerous challenges such as work overload, maintaining operational cost down, balancing budget, resistance to impart knowledge and lack of taking ownership towards their continuous personal development. Davis and Sondlo (2016:31) further assert that these factors create a non-learning environment and encourage “worker” behaviour rather than professional development. The study conducted by Naranjee (2012:3) indicated that due to the shortage of registered nurses in the wards and work overload, student nurses are faced with challenges of having to play two roles of being a student as well as an employee. The above mentioned study also indicated that the Department of Health in South Africa has also acknowledged that due to shortage of registered nurses, there will be an impact on clinical learning and supervision of pupil nurses. It is further mentioned that the complexity of the clinical environment makes it unpredictable and therefore student support, planning for supervision and teaching does not take place according to expected standards. The shortage of registered nurses and unpredictable clinical environment pose a challenge to students as they are expected to adapt and grow into mature professional practitioners at an advanced pace (Bruce et al 2011:261).

Although numerous literatures such as Rikhotso, Williams and De Wet (2014:10) and Nxumalo (2011:290) exist on the experiences of students in clinical placement and support during clinical placement, post-placement reflective feedback from the pupil under study still indicated a gap in clinical support. In this study, the researcher sought to establish the support as perceived by the pupil nurses during clinical placement and propose recommendations to enhance clinical support.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The pupil nurses at their second year level from a private nursing institution are placed in different nursing units within the accredited private hospital for the fulfilment of their

practical component according to (SANC 1993b:1, 3(a), 5). The pupil nurses are normally allocated in a clinical learning environment for a stated period, to work all shifts in order to meet the learning needs at the particular level of training. The nurse educator's availability for clinical supervision is normally limited to day duty thus leaving the student under the care of unit registered nurses, mentors and preceptors to augment the supportive role. The registered nurses, mentors and preceptors provision of clinical support can influence the student clinical learning positively and negatively. This is supported by Kaphagawani and Useh's (2013:184) who stated that clinical learning environment that enhance learning should have friendly staff, with good morale and support and should be willing to teach.

Post-placement reflection sessions are normally held on the first day in class conducted by the nurse educators. The main reason is to establish if the planned objectives have been attained and shortfalls are addressed. The feedback gathered following the sessions indicated a gap in terms of clinical support from nurse educator's accompaniment role. The pupil nurses indicated that too many second year procedures are demonstrated within a short space of time. This poses a challenge to them as they not get the time to practice to get competent in those procedures thus leading to a situation where they are only delegated first year's procedures. It is mentioned by the pupil nurses that the registered nurses are not able to fulfil their mentorship role in facilitating the theory practice integration. The pupil nurses further mentioned that delegation lists in the nursing units indicates that appointed mentors work opposite their shifts and that leaves them with no one supervising to ensure planned clinical learning objectives are attained. Registered nurses do not usually manage to perform this secondary role due to them being occupied with increased role expectation on patient care, thus leaving pupil nurses to work on their own with little supervision. This contravenes SANC (R2598, 1984, as amended), chapter 5, scope of practice of enrolled nurses which stipulate that they should always practice under the direct and indirect supervision of the registered nurses.

Chan (2002:74) describes clinical support as an integral element of human resource development, and therefore indicating a need to evaluate students' perception regarding the clinical support in order to improve and maximise their clinical learning. Literature still reveals that there are problems that hinder the effective clinical support. Nxumalo (2011:290) identified those factors that include negative attitude of staff, differences

encountered between simulated skills and the actual procedures in the nursing units, overpopulation of students in the clinical area, shortages of nurses, utilisation of traditional teaching and inability to draw on clinical experiences during theoretical teaching. Rikhotso et al (2014:10) also highlighted that nursing students experienced lack of support, inhumane attitude from clinical staff, inadequate mentoring and guidance, clinical learning environment not conducive, and isolation from activities. It is revealed that students' experienced emotional stress due to attitudes of some registered nurses and that brought discomfort and discouragement. The pupil nurses under study also seem not to take ownership to ensure that their planned clinical objectives are achieved. This is supported by the Nursing Act (Act No 33 of 2005) which states that there is uncertainty regarding responsibility of clinical accompaniment, guidance and support of nursing students under training.

Although there are several studies that explored other concepts related to clinical support such as mentorship, preceptorship and accompaniment, there is still a need for more studies to focus on clinical support as there are gaps revealed and make recommendations to enhance it. According to the described information and observations gathered from the pupil nurses at their second year level of training it seems that there might be inadequate clinical accompaniment and support. The pupil nurses at their second year level of training seem to lack confidence and query if they will be proficient to pursue expected clinical roles on completion of training. It is on this background and observations that the researcher sought to explore and describe the pupil nurses perceptions toward clinical support during placement.

1.4 PURPOSE OF THIS STUDY

The aim of the study was to establish the perceptions of the pupil nurses at their second year level towards clinical support during clinical placement at the private hospital in the Limpopo Province, South Africa.

1.5 RESEARCH OBJECTIVES

The study aimed at achieving the following objectives:

- Explore and describe the perceptions of pupil nurses at their second year level of study towards clinical support placement at one private hospital of the Limpopo Province, South Africa.

1.6 RESEARCH QUESTION

The following research question led the researcher throughout the study:

- What are the perspectives of pupil enrolled nurse at their second year of study regarding clinical support during clinical placement at the private hospital?

1.7 SIGNIFICANCE OF THE STUDY

The study might provide insight into how best can pupil nurses remain supported in the clinical learning environment to integrate theory into practice so that they can become proficient enrolled nurses. The results of the study might indicate gaps, current strength and weakness on the clinical support offered within the clinical learning environment. This might assist the nurse educators, registered nurses as well as unit managers to realise the importance of their roles in guiding and supporting the pupil nurses at their second year level towards becoming clinically proficient.

The recommendations made from the study might serve as a guideline to the nursing institution, clinical area to improve role learning. The course leading to enrolled nursing is currently being phased out as SANC has proposed new programmes and qualifications. The recommendations might be beneficial in the new proposed course thereby assisting in enhancement of clinical support within the clinical learning environment that foster integration of theory into practice accompaniment (SANC 2006).

1.8 FRAME OF REFERENCE

This study is based on the role theory. The section underneath provides a summary of the theoretical framework. Chapter 2 provides a detailed discussion of the role theory and its application in nursing education**.**

1.8.1 Theoretical framework

According to Wood AND Ross-Kerr (2006:51) as cited by Nxumalo (2011:11) the concept theoretical framework is described as an “explanation which is grounded on propositional statements resulting from an existing theory which pursues to create a specific way at looking at particular phenomenon”. Theories can help direct the process of clinical support. Role theory is described as the study that focus on examining processes and phases of socialisation, individual interdependence, structuring of social positions, processes dealing with conformity and sanctioning, as well as division and specialisation of labour (Mashaba & Brink 1994:318 cited Biddle & Thomas 1996:17). The theory was chosen on the basis that it focuses on interpersonal, interaction and interpretation of behaviour within the institution whereby roles are performed by role players. It also addresses the point that role players’ performance of a role can be predicted, and also focus on how certain behaviours can be anticipated (Hardy & Conway 1988:17).

1.8.2 Assumptions underlying the study

According to Polit and Beck (2008:14) assumptions are described as basic principles that are acknowledged as true on the foundation of reasoning without proof or verification. Assumptions are entrenched in the philosophical base of the study which influence the development and implementation of the research process. The acknowledgement of assumptions leads to the development of a more rigorous study (Burns & Grove 2005:146). Assumptions are not envisioned to be empirically tested, but are underlying propositions, which can be challenged meta-theoretically (Chinn & Kramer 1999:76 as cited by Nxumalo 2011:10). Researchers choose certain assumptions from the paradigm perspective in response to their interaction with the research field. The following assumptions were made by the researcher:

1.8.2.1 Ontological assumptions

Ontology is the study of being (Crotty 1998:10). Ontological assumptions are concerned with what constitutes reality, or what it is. In ontology researchers requisite to take a position regarding their perceptions of how things really are and how things really work. In terms of the study conducted the perceptions of clinical support during placement is

known by the pupil nurses at their second year level. It was necessary that the process and context of the perceptions of pupil nurses at their second year level students in their natural habitat are understood. It is further mentioned that these human realities are observed in their own familiar setting where multiple truths may be discovered due to individual different perception of the phenomena under study (Streubert & Carpenter 2007:21).

1.8.2.2 Epistemological assumptions

Epistemology has been defined as “a branch of philosophy that examines the origin, nature, methods; and limits of human knowledge” (Kothari & Mehta 1993:114). In terms of epistemology, the pupil nurses at their second year of study were able to express their views on how they perceived the clinical support during placement based on their perceptions. The researcher engaged in the role of being a key instrument of obtaining data and analysis. Grove, Gray and Burns (2015:20) assert that due to its interactive and subjective nature, it permits the participants to narrate their experiences; so that human beings can be understood in terms of their uniqueness, dynamic forces and holistic nature.

Burns and Grove (2005:59) describe that the approach also allows the researcher to engage with the participants in the environment. In this study the research took place at a Private hospital where participants are familiar with the setting in the context of the study. Qualitative research utilises flexible procedures to capitalise findings (Grove et al 2015:20). This was done by encouraging the participants through written narratives, focus group interviews and field notes to explore and get meaning the phenomena under study.

1.8.2.3 Theoretical-conceptual assumptions

Theoretical assumptions can be described as “assumptions having the value statement or potential for empirical testing but are assumed true within the theory because they are reasonable” (Chinn & Kramer 2008:293). The assumptions below are based on Role Theory Role theory two main perspectives being functional and symbolic interaction perspective. Functional involves duties and expectations whilst interactionism focuses on what an individual interact with others adopting and acting

their roles. Omer, Suliman and Moola (2016:54) emphasised that adopting both functional and symbolic interactionism approach develops students in terms of professional skills, knowledge, and attitude at the clinical learning environment through an interactive process. The pupil nurses at their second year of study when allocated in the clinical environment have duties and expectations that can be enhanced by interacting with the nursing team. Learning occurs through transformation of experience. Theory and clinical practice should be integrated in order for learning to occur.

1.8.2.4 Methodological assumptions

Methodological assumptions refer to the relevant methods that are used in the research process (Mouton 1996:124). In this study it was assumed that: clinical support as perceived by the pupil nurses at their second year of study at a private hospital in the Limpopo Province was not adequate to enhance theory-practice integration. The perception was best understood by using the qualitative, explorative, descriptive and contextual designs. Focus group interviews, written narratives and field notes were utilised for data collection data in this study. The researcher utilised non-probability, purposive sampling to choose the study participants. The participants who were selected and qualified according to the inclusion criteria participated in the study. The participants were able to describe their perception regarding clinical support at a private hospital in the Limpopo Province.

1.9 DEFINITION OF KEY CONCEPTS

- **Perception**

Perception is a process whereby people gather information about the environment through the five senses, which are sight, smell, hearing, touch and taste. The interaction of these senses assists people to get meaning of themselves as well as the environment. People may perceive the same thing differently, merely based on their interpretation of what reality is, and not on reality itself. Factors that can influence perception stem from the perceiver, the target and the situation. Those within the perceiver include attitude, experience, interest, motives and expectations. Other factors from the target include background, sounds, size and motion. Lastly factors from the

situation are time, work setting and social setting (Robbins, Judge, Odendaal & Roodt 2009:119; Steinberg 2013:69).

- **Clinical**

Clinical means the environment pertaining to bedsides observation and treatment of patients, and is not limited to bedside care only but also extend to a variety of workplace setting including non-institutionalised activities such as day care centre, schools, surgeries, nurseries as well as community practice settings (Hughes & Quinn 2013:356).

- **Support**

Support, according to Mellish, Brink and Paton (2000:76), is described as being there for a person and availing oneself when needed. *Oxford Concise Medical Dictionary* (2010:1192) defines support as being actively interested to provide assistance, enable, to give strength, encourage, and back up someone. Support when relating it to nursing can be described as that component of the caring process, and it has often being correlated to strengthening and adaptation. For the purpose of this study support can be defined as being there for pupil nurses, accepting them, and being non-judgemental and open to communicate in order to help them identify and manage the challenges they come across and thus enabling them to trancede from the lowest to the highest levels of nursing education (Mkhwanazi 2007:12).

- **Clinical learning environment**

Clinical learning environment is a clinical setting wherein pupil nurses are brought into contact with patients in order to achieve specific learning outcomes related to patients' need through provision of a holistic approach that include physical, spiritual, psychological, spiritual and social support. Such an environment should be conducive in terms of support from supervisors, mentors, preceptors, and nurse educators thus fostering team spirit wherein the student feels that they belong. Student nurses should be encouraged to use their initiatives and utilise critical thinking and judgement skills freely to integrate theory into practice (Hughes & Quinn 2013:361).

- **Pupil nurses at their second year level**

A pupil or student is defined as an undergraduate or postgraduate person who is studying at a university or college to enter a particular profession (*Oxford Concise Medical Dictionary* 2010:1484). According to South Africa (2005:25) in terms of Section 45(1), pupil nurses at their second year level means an individual enrolled under Section 24 at the SANC as a pupil nurse and are undergoing the second year of training at an approved nursing institution.

- **Private hospital**

Black's Medical Dictionary (2005:582) describes a private hospital as an institution that provides medical and dental care to patients who pay for their care directly through private medical insurances or employer funded private insurance and is not funded by the state or a public body and it operates on profit.

- **Nurse educator**

Mkhwanazi (2007:13) defined a nurse educator as a person who has accomplished a course in nursing education from a Department of Nursing Science at any Republic of South Africa university and is registered as a nurse educator with SANC (R118 of 1987, as amended).

- **Registered nurse**

Registered nurse is a person who is registered as a registered nurse or as a midwife in terms of the Section 31 of the Nursing Act (South Africa 2005:25), and this person is responsible for caring, supporting and treating of health care consumers to achieve or maintain health their health where possible and if cannot do that ensures that their dignity and comfort is maintained till they die.

1.10 RESEARCH DESIGN AND METHODOLOGY

1.10.1 Research design

A research design is an overall plan for collecting data and attaining answers to research questions (Brink, Van der Walt & Van Rensburg 2012:217; Polit & Beck 2012:58). In this study qualitative, exploratory, descriptive, and contextual research approach was followed. Qualitative research is a “systematic, interactive, subjective approach that describes life experiences and gives them meaning”. This approach facilitated the understanding of human experiences from the viewpoint of the participants themselves in their own context (Grove et al 2015:20). The researcher followed a systematic approach to capture the support as perceived by the pupil nurses at their second year level to better understand how best the clinical support can be enhanced in order to develop them into proficient nurse practitioners.

Explorative, descriptive and contextual designs were used to explore and describe the perceptions of the pupil nurses at their second year towards clinical support during their clinical placement in one private hospital in the Limpopo Province. Exploratory qualitative research component seeks to explore and give answers in different ways about how a phenomena and processes occur (Polit & Beck 2012:227). Descriptive component of the research design is aimed at describing and documenting participants’ behaviours and or experiences in order for the researcher to have an understanding of the phenomenon studied (Polit & Beck 2012:226). Contextual research design seeks to explore and give answers into different ways about how phenomena and processes take place with regards to the clinical support of the pupil nurses at their second year level placement in a private hospital (Polit & Beck 2012:18).

More details on research design will be discussed in chapter 3 of the study.

1.10.2 Research setting

Brink et al (2012:121) elucidate that qualitative research takes place in real-life situation. In this study, data were collected from pupil nurses at their second year level placed within the clinical learning environment, which is the private hospital. The private hospital is selected because it is an accredited clinical placement for the private NEI. In

the private hospital the pupil nurses are under the supervision of the nurse educators and registered nurses to fulfil their clinical expectations. Further details are explained in chapter 3.

1.11 RESEARCH METHODOLOGY

The research methodology describes the methods and research procedures followed when conducting a study (Polit & Beck 2012:12). In this study the research methodology that was followed included: population, sample and sampling method, data collection and analysis, measures to ensure trustworthiness and ethical considerations (see chapter 3 for detailed discussion).

1.11.1 Population and sample

The population is a specific group of individual or elements who are the focus of research (Grove et al 2015:250). In this study, the population refers to all pupil nurses at their second year level who are enrolled with the SANC's regulation relating to the programme leading to enrolment as a nurse (SANC R2175 of 1993, as amended). The population consisted of twenty pupil nurses at their second year level.

De Vos, Strydom, Fouché and Delport (2011:360) describe a sample as a component of the population considered for actual inclusion in the study. Grove et al (2015:37) refer to sampling as a process of selecting participants who are representative of the population under study. The researcher utilised non-probability, purposive sampling to choose the study participants. In non-probability sampling, the researcher judges and selects those participants that know most about the phenomenon and are able to clarify and narrate the differences within the information provided (Grove et al 2015:250). Berg and Lune (2012:52) describe purposive sampling as a process whereby the researcher utilises their special knowledge or expertise about the phenomena to select subjects who represent the population and have information about the phenomena studied. The sample consisted of twelve participants. The researcher was of the opinion that second year level students have better knowledge and understanding of the dynamics of clinical support when allocated in the clinical setting for practice.

1.11.2 Data collection

Data collection is the process involving selection of subjects and gathering data and is dependent on the research design and measurement methods. Qualitative research utilises several data-collection methods, such as interviews, observation, and written documents and records (Grove et al 2015:310). In this study, written narratives and focus group interviews were utilised to collect data from the participants. The scripts containing the written narratives were collected, and this was followed by audio tape-recorded focus group interviews and field notes were taken on observable behaviours (non-verbal cues) from the participants (Creswell 2009:139). Data was safely stored and only the researcher had access to them. Chapter 3 will provide more details on data collection methods.

1.11.3 Data analysis

According to Polit and Beck (2012:557), data analysis is a process involving organising data, including interview transcripts and field notes so that the research questions are addressed and meaning is derived. In this study, data analysis was done simultaneously during and after data collection. Tesch's Open coding qualitative data analysis method was utilised adhering to the process below:

The voice recorded data was transcribed verbatim. The researcher read through the verbatim transcript to get the whole sense of the interviews and familiarised herself with data. Ideas that come to mind were written down. The researcher selected the shortest, top of the file and most interesting transcript, reread each and differentiated between meaning units and wrote down any ideas that come to mind again. Coding and categorising began as soon as data collection had begun. Coding was used to organise the data into themes and subthemes. Categorising was also used through the use of manual analysis whereby the researcher reviewed all recorded information that the researcher has obtained during the course of the data collection. The researcher also included the written narratives and the field notes in the establishment of the themes. Similar themes were established and relationships amongst the themes were compared. The researcher .made a summary of the themes and sub-themes identified before sending to the independent co coder. Once the co-coder had completed the independent coding, common themes and sub-themes of the independent coder and

the researcher were identified and summarised. (See Annexure F for identified themes.)

1.11.4 Measures to ensure trustworthiness

Trustworthiness refers to the study applicability, consistency and neutrality of findings. Scientific rigor in qualitative studies is measured by the extent to which the findings are true to the data and the research context (Babbie 2013:25). Measures to ensure trustworthiness of the study evaluate whether the findings reflect the participants' experience and not the researcher's perceptions. The four criteria for establishing trustworthiness, namely: credibility, dependability, conformability and transferability were applied in the study (Polit & Beck 2012:584) (see chapter 3 for further details).

1.11.5 Ethical considerations

When human beings are utilised as study participants, care must be exercised to ensure the protection of their rights (Polit et al 2012:150). In this study, the researcher attained written permission to conduct the study, and respected the participants right to privacy, self-determination; confidentiality; fair treatment, protection from harm and discomfort and scientific honesty. In chapter 3 the ethical considerations will be discussed in detail.

1.12 OUTLINE OF THE STUDY

Chapter 1 provides an overview of the study.

Chapter 2 comprises a literature review.

Chapter 3 discusses the research design and methodology.

Chapter 4 presents the data analysis and interpretation of the results.

Chapter 5 provides the findings, limitations of the study, recommendations and the conclusion.

1.13 CONCLUSION

This chapter presented an overview the study, the background, the research problem and the purpose of the study. Definitions of the key concepts were given and the design and methodology was discussed.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter explores and reviews available literature on the concept of clinical support and related aspects in the nursing education context. The theory underpinning the study will be explained. The position of the SANC (R2175, 1993, as amended) on clinical support and teaching is also discussed. Challenges and encounters of student/pupil nurses about the clinical support are explored. In this study source of information, namely; journals, articles, books, dissertations/thesis, reports and papers presented on the internet as well as the SANC's rules and regulations were also consulted.

The main aim of the researcher when conducting this literature review was to establish whether they have been any previous studies conducted on perceptions of pupil enrolled nurses at their second year level towards clinical support. This is conducted with the aim of identifying gaps, and if any intervene utilising recommendations provided to enhance clinical support.

2.2 THE DEFINITION OF THE CONCEPTS CLINICAL ENVIRONMENT, SUPPORT AND CLINICAL SUPPORT

2.2.1 The concept clinical environment

Clinical environment is the setting which pertains to bedside observation and treatment of patients, and is not limited to bedside care only but also extend to a variety of workplace setting including non-institutionalised activities such as day care centre, schools, surgeries, nurseries as well as community practice settings (Hughes & Quinn 2013:356). Clinical environment in the study pertains to the accredited clinical learning environment setting such as the hospital where pupil nurses can come into contact with patient and all other categories of nursing staff and other members of the multidisciplinary team whereby they should be exposed to learning opportunities and be able to master the nursing skill taught, and become proficient practitioners.

2.2.2 The concept support

Oxford Concise Medical Dictionary (2010:192) defines support as being actively interested to provide assistance, enable, to give strength, encourage, and back up someone. Orem (1995:17) view support as providing the next person with material resources as closely related to the giving of physical and psychological support. Support is categorised into four categories namely: emotional, information, instrumental and appraisal support. Nurse educators and other key people such as registered nurses can offer emotional support through listening, advising and assisting. The instrumental support can be ensured through ensuring that resources are adequate. The information support can be obtained through in searching of information from different sources including books and developing own material, providing handouts, utilisation of photos ,different media including television, computers, and also consultation from subjects specialists. The appraisal support is attained through affirmation and giving of feedback to pupil nurses (White & Ewan 1991:126).

2.2.3 The concept clinical support

Clinical support is fully acknowledged globally that it forms an integral part of nursing education. It enhances the development of nursing students into becoming proficient practitioners. Joolaee, Amiri, Farahani and Varaei (2015:1) is of the opinion that even though clinical support has been described in a number of ways and is is one of the major needs of nursing students during clinical education it is however not clearly defined according to literature. It is further mentioned that clinical support is categorised into four subthemes namely: strengthening independence, providing help, understanding educational needs and providing feedback.

The Nursing Act (Act No 33 of 2005) asserts that there is uncertainty regarding responsibility of clinical accompaniment, guidance and support of nursing students under training. When one refers to clinical support from SANC, it is defined in terms of related concepts such as supervision and accompaniment. Clinical supervision is defined according to SANC (R173 of 2013) as assistance and support that is extended to the pupil nurses by the registered nurse, midwife, or staff nurse in a clinical facility and the main aim being to develop them into competent and independent practitioners. Regulation R683 (SANC 1993) refers to “accompaniment” as conscious and purposeful

guidance and support offered to students based on her/his individual needs creation of learning opportunities to foster growth from passive to the level of involvement, independent and critical thinker. It further stipulates that there should be direct involvement as well as physical presence of the nurse educator, led through by availability of guidelines as well as learning aids.

In this study clinical support is defined as guidance offered to pupil nurses by experienced nurse educators, unit managers, registered nurses, mentors, preceptors and other members of the health team through cognitive, psychomotor and affective skills enhancement with the aim of developing pupil nurses into proficient providers of care.

2.3 THEORETICAL FRAMEWORK

Theories can help guide the process of clinical support. The theory that will be utilised to support and ground the study is the role theory. The role theory has been identified with regard to its application in enhancing clinical support of pupil nurses to be socialised into the new role of enrolled nurse upon completion. Pupil nurses at their second year level observe during interaction, the nurse educator's role is to transfer learning to them and equip them and they imitate through modelling the observation to become proficient enrolled nurses.

2.3.1 Role theory

Integration of theory into practice is important in the education and training of pupil nurses. It is important because nursing is a hand on profession which requires of nursing practitioners to be highly skilled and efficient. The role of pupil nurses are learning and mastering their second year procedures in the clinical environment. During this period pupil nurses are allocated in the clinical setting, to be supported, guided and assisted to apply what they have learnt in the classroom to patient care. This clinical supportive role first and foremost is the responsibility of the nurse educator and secondly other support system such as registered nurses and mentors. The study emphasised the interaction of nurse educators, other support system such as registered nurses, and mentors with pupil nurses at their second year level and describes the interpersonal relation in the clinical area.

Mashaba and Brink (1994:318) cited Biddle and Thomas (1996:17) when describing role theory as the study that focus on examining processes and phases of socialisation, individual interdependence, structuring of social positions, processes dealing with conformity and sanctioning, as well as division and specialisation of labour. The theory was chosen on the basis that it focuses on interpersonal, interaction and interpretation of behaviour within the institution whereby roles are performed by role players. It also addresses the point that role players' performance of a role can be predicted, and also focus on how certain behaviours can be anticipated (Hardy & Conway 1988:17).

It is asserted in Merton (1957:368) that a part that a person play (role) and the title position one occupies (status) in the process of interaction is the central focus of the Role Theory. The researcher is of the opinion that provision of clinical support evolves around the interaction nurse educators, other support system such as registered nurses, and mentors with pupil nurses at their second year level. Seboni, Magowe, Uys, Suh, Djeko and Moumouni (2013:3) describe role theory as how people are socialised into roles and how they perform within this role.

In the proposed study, the role that pupil nurses at their second year have is to acquire knowledge and skills based on their interactions with other members of the nursing team. The interaction between the nursing manager, registered nurses, enrolled nurses auxiliary nurses, will help pupil nurses at their second year to develop meaning and thus be able to enact the expected roles.

Role theory deals with two main perspectives being functional perspective and symbolic interaction perspective. Functional involves duties and expectations whilst interactionism focuses on what an individual interact with others adopting and acting their roles. Omer et al (2016:54) emphasised that adopting both functional and symbolic interactionism approach develops students in terms of professional skills, knowledge, and attitude at the clinical learning environment through an interactive process. The pupil nurses when allocated in the clinical environment have duties and expectations that can be enhanced by interacting with the nursing team.

2.3.1.1 The functional perspective

Lai and Lim (2012:32) describe the functional perspective as a situation whereby individuals are exposed to hospital policies, job descriptions and doctors' orders. Cultural conditions on the other hand involve idea systems that are common within that profession which can be expressed by means of words, ceremonies and symbols. The pupil nurses are expected to learn about the hospital policies and understand their job description based on the delegation set by registered nurses. The following concept namely: role, status, role performance will be discussed from their perspective view in application to clinical support.

2.3.1.1.1 The concept role

Role refers to expectations that people have over the behaviour of a person in certain position or status in the society (Du Toit & Le Roux 2014:85). Role theory explain that actions result from the roles performed, and those actions being learnt are voluntarily. Pupil nurses at their second year level have to take decision based on what they have been taught by registered nurses and nurse educators.

2.3.1.1.2 The concept status

Du Toit and Le Roux (2014:85) define status as that esteem (social standing) attached to a specific and recognised position occupied by a person in a social group or society. In the study status refers to the learning position held by the pupil nurses in the clinical environment. The nurse educator and other forming the support structures such as the registered nurses and mentors have obligation of providing clinical support to the pupil nurses under study.

2.3.1.1.3 The concept role performance

Role performance is when an individual enact a role. Behaviours and activities carried out at specific situations forms a role. Role performance is goal directed and it constitutes a behaviour that was learnt. Individual role performance is influenced by how other performs their expected roles within that specific situation. According to the role theory the performance of the role can lead to role stress, strain, ambiguity and

overload. Blanchette (2015:27) described namely: role stress, strain, ambiguity and overload as follows:

- **Role stress**

Blanchette (2015:27) describes role stress as when social structure causes demands on the individual which are difficult or impossible to meet. Pupil nurses experience stress when they do not meet the leaning needs in the clinical environment and when job descriptions are not clear. The registered nurse's role of patient care, administration, research and teaching results in them being unable to meet the expectation of clinical support to pupil nurses.

- **Role strain**

Blanchette (2015:8) refers to role strain as the state of distress that an individual experience when exposed to role stress and the individual is unable to fulfill role obligation. In this study the pupil nurses will experience feelings of frustration and tension and may end up developing a negative attitude towards the clinical environment especially when their learning needs are not met and as well as fulfilling the job descriptions.

- **Role ambiguity**

Role ambiguity results from lack of clarification of the role expectation or disagreement (Du Toit & Le Roux 2014:93). In this study role ambiguity may occur when the registered nurses role of mentorship is not clarified and expectations are not tabled. The registered nurses may not be able to fulfil their mentorship role in providing clinical support.

- **Role overload**

Role overload is described as when an individual experiences shortage of resources to possibly excessive demands (Blanchette 2015:27). The two roles of pupil nurses at their second year level create too much workload thereby affecting their learning or employment objectives. The nurse educators and registered nurses as well might not

be able to accommodate all the pupil nurses under study due to work overload caused by staff shortage.

- **Role taking**

According to Du Toit and Le Roux (2014:93), role taking is explained as capacity to take role of others. In the study role taking is assumed by pupil nurses at their second level when imitating other role models behavior through interaction and observation to understand the rationale behind the behavior.

2.3.1.2 Symbolic interaction perspective

According to an article on International Encyclopaedia of Marriage and Family (2003:1), symbolic interaction is defined as that part of human life that is lived through the symbolic sphere. It is further added that symbols have shared meanings, and these meanings are formed during social interaction. It further indicates that through language and communication symbols provide the means through which reality is formed. It is also mentioned that reality is a social product, and the self, mind society and culture develop and it relies on symbolic interaction. It is further stated that the physical environment is also interpreted through symbolic interactions. Carter and Fuller (2015:1) also describe symbolic interactionism as a micro-level theoretical framework and perspective in sociology that focuses on how society is created and sustained through repeated interactions among individuals. Symbolic interactionism focuses on examining the society from “bottom up” shifting the focus to micro level process that occur during face to face encounter in order to explain the operation society.

2.3.1.2.1 Implication for the symbolic interaction on clinical support

In this study, the pupil nurses at their second year of study needs to interact with others in order to interpret how others pursue the roles that are expected within their second year of study, namely; administration of medication (oral, intramuscular, suppositories, inhalations); perform wound dressings; removal of wound drains; sutures; insert urinary catheters; observation of patients’ neurological functions; as well as perform electrocardiograms. They can manage to enact such roles after carefully observing people around their environment; namely; mentors, preceptors, registered nurses and

getting enough support. After their observation, they will reflect on what they have observed and they will decide to imitate that. The onus lies on whether what was observed was done in a good attitude, adequately and correctly enacted and the condition of the environment in which it was enacted. The pupil enrolled nurses at their second year level define clinical support by the way the nurse educators, registered nurses and mentors interact with them.

2.3.1.3 Socialisation for roles

In a study conducted by Lai and Lim (2012:31), it is asserted that every pupil nurse enters the nursing profession with a lay (unsocialised) concept of what nursing is, or the only conception may be that is acquired from nurses they earlier met and try and enact those roles. When they commence with nursing, they are socialised into the professional understanding which they acquire in nursing schools. The following two concepts explain how socialisation takes place:

- **The concept socialisation**

Lai and Lim (2012:32) describe the socialisation as processes whereby new roles, skills, knowledge and characteristics of a group in a society are learned. It is further stated that in these processes, members acquire attitudes and behaviours which makes them to fit within the society. Pupil nurses will acquire new skills, characteristics of the nursing profession and knowledge in the clinical environment only when support is adequate.

- **The concept professional socialisation**

Professional socialisation as a process whereby norms, values and way of viewing the profession are transmitted in order that the member can view himself as a member of the profession, thus assists the member to fully adjust into the professional world. Each and every professional group has values, so pupil nurses also learn values which are guidelines for caring and conducting one in the acceptable manner during delivery of health care service. It is further noted that Role theory emphasises the importance of preparing the students to enable them to face a particular job expectation (Lai & Lim 2012:32).

It is mentioned in role theory that individuals learn the roles through two processes being the one of interacting with groups and significant others and learning from role play, identifying, modelling, instruction, observation, trial and error, as well as role negotiation. In this study, the pupil nurses at their second year level are professionally socialised by following the second year curriculum of nursing study and has to fulfil both theoretical and practical component. This is where the theory that was learned in class has to be fully integrated into practice in the clinical learning environment. During this time, the pupil enrolled nurses at their second year of study have to learn values, interact and identify themselves with mentors. For socialisation to occur the pupil nurses at their second year of study has to observe how second year procedures such as wound care are performed, and they should be given chance to practice and be corrected. They have to be demonstrated how policies, procedures and records are utilised in providing quality patient care. They also need guidance to familiarise themselves in understanding and interpreting, for example, the doctors' prescription and all terminology related to their level of study.

2.4 ROLE PLAYERS IN THE PROVISION OF CLINICAL SUPPORT

The following role players will be described namely: the nurse educator, mentors, preceptors, registered nurse, the patient, pupil nurse at their second year level, clinical learning environment and SANC will be discussed to understand the input they have on clinical support.

2.4.1 The nurse educator

A nurse educator is a person who has accomplished a course in nursing education from the Department of Nursing Science at any South African university and is registered as nurse educator with SANC (R118, 1987, as amended). A nurse educator has four key elements namely to liaise, teach, clinical practice and research. The most important focus areas in the practice area that a nurse educator should be devoted to includes namely: student support, mentorship, clinical credibility and research (Hughes & Quinn 2013:384). In this study the role of the nurse educator on clinical support comprising of accompaniment, preceptorship, clinical credibility and research, will be explored.

The support of students during clinical practice is one of the most important functions of the nurse educator. This starts from preparing the students before they go into the clinical setting. The students receive theory and clinical procedures are demonstrated while expectations are clarified. Students are orientated and guided on to how to construct learning contracts wherein learning objectives to be attained in the clinical area are written down. Guidance is also offered to utilise reflective diaries to describe situations that can be referred to later for reflection (Hughes & Quinn 2013:385).

Student nurses are then placed in the clinical learning environment in order to integrate theory and practice to become skilled, knowledgeable and proficient providers of high quality nursing care. They can only be able to do so when being guided and supported by the nurse educator to make connections between what has been acquired in the classroom with what is presented in the real life situation. According SANC (R171, 2013) on guidelines pertaining to student accompaniment, it is stipulated that the nurse educator has to spend 30 minutes per fortnight accompanying a student.

However, there is a concern over the nurse educator's role as a specialist in different department because less time is devoted in the clinical learning environment. It is clear that the nurse educator should be responsible for teaching in both theory and practice but it seems like the devotion to practice is less than that of theory and that contradicts the main aim of clinical teaching being to produce a competent independent practitioner. The time that the nurse educator needs to spend in the clinical learning environment is vital, with the main reason being to spend it with the pupil nurses simulating and demonstrating to foster theory and practice integration.

Integration depends on the nurse educator who will identify the theory mastered in class and all other science to be integrated within the clinical learning environment. Even though it is clearly outlined that the chief person responsible for theory and practice integration is the nurse educator, the clinical instructors, ward registered nurses and unit managers should supplement and compliment this role. The nurse educator needs to spend more time in practice areas being physically present in order to teach students (Bruce et al 2011:254). However, Nxumalo (2011:290) and Rikhotso et al (2014:10) identified that there is ineffective clinical support that leads to a gap between theory and practice integration that still need to be curbed. Nxumalo (2011:290) and Rikhotso et al (2014:10) further on concurred that there are problems that hinders the effective theory

practice integration in the clinical area. In their studies it is revealed that nurse educators are still utilising the traditional teaching and are unable to draw on clinical experiences during theoretical teaching.

2.4.1.1 The scope and content of the nurse educator's clinical responsibilities towards clinical support

The SANC (R425, February 1985:2) as amended requires that cognitive, psychomotor, and affective skill be included for the application of scientific approach to nursing. The nurse educator supportive role in the psychomotor, cognitive and affective development of the students is of paramount importance to the pupil nurses at their second year level. The three domains cognitive, psychomotor, and affective will be discussed respectively.

2.4.1.1.1 Clinical support through cognitive enhancement

Bastable (2014:436) defines cognitive support as the thinking domain which involves acquisition of knowledge, development of pupil nurses' intellectual abilities, thinking processes capacities, and understanding. Hughes and Quinn (2013:387) described the teaching learning strategies that can be deployed to offer cognitive support to the pupil nurses as: teaching on a one basis, hand over, reports, case conferences, clinical rounds, reflective, diary, learning contracts, critical incidents technique, and teaching a motor skill. The strategies are explained as follows:

- **Teaching on a one basis**

Teaching on a one basis involve situation that occurs on the spot whereby the nurse educator and the student can each pose a question resulting in a discussion and critical thinking is stimulated. The challenge could be that either the educator or the student could not be adequately prepared and as this takes place in front of other staff members as well as the patient they might feel not yet competent or credible. The students need to be guided and be allowed to make mistakes in order to learn, and the nurse educator may refer and provide answers to the questions.

- **Hand over**

Hand over is the handing over of patient's report which could be conducted by the senior member verbally with the nursing team utilising the patient's documents to communicate the care as planned and carried out. It can be conducted non-verbally as well at patient's bedsides utilising the documents. For proper handover that will enhance effective clinical support there needs to be workshops on how to conduct it and the patient should be incorporated where possible. Anderson, Malone, Shanahan and Manning's (2014:662) assert that when pupil nurses are allowed to participate in hand over, it awards them the responsibility of patients to be looked after. There is a need to develop handover skills in order to prepare pupil nurses adequately.

- **Case conferences**

Case conferences involve one member presenting a patient and a discussion be held amongst all nursing team members in the evaluation of nursing care rendered of a particular patient (Hughes & Quinn 2013:388). This will provide questioning and critical thinking for students. The case conferences will encourage students to prepare and enable them to obtain valuable feedback during discussions. The student will develop problem solving skills, sound judgement and decision making abilities.

- **Reflective diary**

Reflective diary provides an opportunity for student to write down the situations as they encounter them during clinical placement so that they could later reflect on them. The input of the nurse educator and others that provide a supportive role would assist in clarification and assimilation of knowledge that may enable theory practice integration. McLeod, Barr and Welch (2015:444) assert that there is still a need for students to get acquainted in utilising the reflective journals.

- **Critical incidents technique**

Critical incidents technique is a strategy that could be utilised by a pupil nurses whereby the positive and negative incidents that occurred are analysed to give new sight into nursing (Hughes & Quinn 2013:390).

2.4.1.1.2 Clinical support through enhancement of psychomotor domain

The psychomotor domain is referred to as the skill domain. This involves the utilisation of fine and gross motor skills in carrying out the procedure. However the other two domains namely; affective and cognitive are required in the execution of the psychomotor skill. The affective is integrated as it adds value or worth in relating to the patient in the skill performed whilst cognitive will instil the principles, processes and relationship in carrying out the process. Although the three are integrated the psychomotor domain can be evaluated separately (Bastable 2014:442).

Daves level of psychomotor learning as discussed in Bastable (2014:445) include the following:

- Imitation − at this level the pupil nurses observes actions and follow them. There needs to be time as there are errors and repetition to learn the skill.
- Manipulation-accuracy in performing a skill.
- Precision − there is logic and errors are minimal.
- Articulation − the speed in carrying out the skill is enhanced.
- Naturalisation − sequence of carrying out a skill is automatic. It becomes a way of doing things.

This commence at the educational institution whereby the nurse educator demonstrate nursing procedure in the simulation laboratories to the students as a follow up of theory provided. Hughes and Quinn (2013:390) assert that although it seems convenient and easy to demonstrate in simulation the nurse educator has the responsibility of ensuring that is carried out at clinical setting under real situations.

Students should be awarded an opportunity to practice in simulation before being exposed to real life situations. Mashaba and Brink (1994:51) assert that the nurse educator should expose them to the clinical learning environment where there are adequate opportunities to learn, and reach out directly where they are allocated. There should be demonstration of sensitivity from the nurse educator to the learning needs of the students where they are allocated. In contrary to that Nxumalo's (2011:44) study revealed that students feel that in the wards they are taught more quickly than in the

clinical skills laboratories. The students should be allowed to explore the normal to more challenging situations, so that they should be able to handle ambiguity thus enriching them to be self-confident in making decision irrespective of the uncertainties of the results.

2.4.1.1.3 Clinical support through affective skill enhancement

Affective domain as the sphere that deals with the realm of feelings and attitudes, constitute the caring function. Attitude and values plays a major role in this domain. Attitude is a feeling about certain things and could either be negative or positive. Value is what the individual consider desirable and has a high emotional component (Hughes & Quinn 2013:110). The five levels of enhancing the affective domain according to Hughes and Quinn (2013:111):

- Receiving − pupil nurses becomes aware of existence of something
- Responding − they respond according to how fulfilled they feel
- Valuing − acceptance and internalisation of values and attitude
- Organisation − valued things are organised and arranged logically
- Characterisation − it becomes philosophy of pupil nurses life

Role modelling the professional behaviour to enhance affective behaviour

Moulding the student to start thinking like professionals, and have a larger view of their practice, and not only be self-interested, but be knowledgeable, fully developed in value inherent skills. Murray and Main's (2005:30) describe the strategies to ensure that nurses are a positive role model for nursing students to include the following:

- Being aware of body language, facial expressions and eye contact
- Smiling, being friendly and introducing yourself to the student
- Showing enthusiasm for the nursing profession and discussing nursing in a positive light

2.4.1.2 Accompaniment role of the nurse educator

R683 of 1993 refers to “accompaniment” as conscious and purposeful guidance and support offered to student based on her/his individual needs creation of learning opportunities to foster growth from passive to the level of involvement, independent and critical thinker. It further stipulates that there should be direct involvement as well as physical presence of the nurse educator, led through by availability of guidelines as well as learning aids. It helps in critical thinking, problem solving, assessment of pupil nurses and overall guidance and support of pupil nurses also referred to as direct assistance and support by a registered nurse/midwife with the aim of developing a competent, independent practitioner (SANC 1992:6). Bruce et al (2011) support by describing clinical accompaniment as a process whereby there is physical presence and direct involvement of a nurse educator who supplements her tasks by utilising guidelines and learning resources to close the theory-practice gap.

Therefore, accompaniment means to facilitate, guide and to support the students bearing in mind their learning needs, outcomes and assessment methods that the accompanist and the student should discuss. The role of the nurse educator in accompaniment involves to encourage, support, liaise, represent, monitor, coaching, negotiating and offer counselling. According to these definitions of accompaniment, the student is accompanied to the patient or client to observe or practise clinical skills under the supervision of a registered nurse, which could be a nurse educator, mentor, in order to assisting the student to acquire clinical skills. The student should actively participates in learning and, as such, would ultimately gain necessary knowledge, values, attitudes and mastery of clinical skills. Planning is mandatory in the form of programmes together with the student, Mogale (2011:17) revealed that although clinical accompaniment is mandatory for student nurses there are still concerns. Xaba’s (2012:34) study revealed that there is lack of collaboration between the two facilities which is the university and the clinical placement areas and this created problems between the two facilities. Nurse educators also do not take student accompaniment as part of their duty and most of them do not do it at all. It is therefore not easy to curb the theory-practice gap which is important in the student support.

Lekhuleni, Van der Wal and Ehlers (2004:18) are of the opinion that there are similarities and differences amongst concepts applicable to accompaniment. It is further

asserted that the similarities among mentorship, facilitation, preceptorship, supervision and role modelling are that they all deal with encouraging student nurses. Mentorship, facilitation, preceptorship, supervision and role modelling is done through provision of guidance and maintenance supportive relationship with students, nurse educators and unit supervisors. In all these concepts the underlying similarity is mutual trust and respect. However the main difference is that mentorship is provided all through the course of the programme on a counselling, advisory and friendly base by registered nurses and peers. On contrary preceptorship is provided by competent registered nurses who are based in the unit on a permanent basis thus promoting stable clinical support. Therefore mentors and preceptors focus on enhancement of developing the student professionally through offering mentorship, preceptorship, facilitation, supervision and role modelling to the students in the clinical learning environment Lekhuleni et al (2004:18).

2.4.2 Mentors

Hughes and Quinn (2013:371) defined a mentor as a qualified and knowledgeable staff member of the clinical setting who agrees formally to offer educational and personal support to a student during the duration of clinical placement. It is further elaborated that this form of support may take place in the form of teaching, guiding, counselling, evaluating and supervising.

The functional perspective of the role theory as discussed earlier asserts that senior and older personnel from a profession has to orientate and induct new members of the profession on what is expected from them, as well as show them how and when to do that. The mentorship support helps students to transcend from the unknown to the known world and to progress through developmental phases taking place during their training as well as in education.

Bosher and Pharris (2012:3) emphasise that mentorship has power in improving student retention, growth, helps students to acquire complex issues. In the same article, students were quoted stating that a mentor is someone who shows enthusiasm, is friendly, approachable, demonstrate patience and understanding coupled with great sense of humour. The five recommendations as described in the above-mentioned article in developing a strong effective mentor-mentee relationship include dedication,

honesty and truth, mutual trust and respect, positive and caring attitude as well as appreciation of mentee as a whole person. However, Wilson, Brannan and White (2010:317) revealed that mentorship and mentors to date are still reluctant and some do not engage to perform their mentorship role. This is in contrast with mentoring as it is described as a process of sharing knowledge, skills and life experiences from an experienced employee to a developing employee for attainment of growth and development by (Heigan 2014:2). A mentor does this through offering guidance, support so that the developing employee is assisted to face new challenges, correct mistakes and motivate them during difficult times (Heigan 2014:2).

2.4.3 Preceptorship

According to The Nursing Education Stakeholders (NES) adopted at the Nursing Summit (2011:2), a clinical preceptor is described as an experienced and competent registered nurse who is positive about nursing, students and herself, who serves as a clinical educator in the clinical learning environment and is employed by a Higher Education Institution (HEI). However, Billings and Hallstead (2012:327) as well as Hughes and Quinn (2013:375) define preceptor as an experienced nurse; it could be a midwife or community nurse who act as a role model, facilitating, helping, guiding, and assessing a student or a newly qualified nurse in the clinical learning area over a specified period of time. Bruce et al (2011:255) further assert that preceptors do not receive formal training. Preceptorship occurs when registered nurses work alongside the nurse in an organised, structured manner, role model the expected behaviour, helps in theory and practice integration (Myrick 1998) cited in a study conducted by Lukheleni et al (2004:17).

Preceptor needs to be guided and supported through preparation courses in education and assessing in clinical practice, or attend specifically designed in house courses to help them understand the student learning needs and the different methods of facilitating clinical learning as well as being a good assessor (Hughes & Quinn 2013:379). It was also revealed from the study conducted by Omer et al (2016:54) that the frequency of engagement of preceptors in their roles of facilitation and as educators still needs attention.

Bastable (2014:482) asserts that a preceptor who assume clinical teaching role and who are normally expert clinicians needs to be orientated effectively to carry out their roles through workshops and coaching sessions. Botma, Jeggels and Uys (2012:1) described that preceptors that are either appointed by the nursing education institution or health service may address the issue of inadequate support of students. It is further mentioned that however, preceptors should be well trained to facilitate learning in the complex and dynamic clinical environment. In a study conducted by Xaba (2012:1) in the Western Cape Province, registered nurses attend a training programme to prepare them for the role of preceptor. It is further stated that after completion of the training it is unclear how the trained nurse preceptors perceive their preparation for the role. The perceptions of preceptors may influence their commitment to their role.

Bruce et al (2011:255) support an article on mastering the preceptor role by Burns et al (2006) by highlighting the following principles:

- Preceptors should plan the clinical setting properly and be familiar with the students' expected period of stay, their objectives, the type of patients the student might need and the records involved.
- Student goals should be looked into on the first day and uncertainties' clarified.
- Follow-up and assist in attainment of goals, role modelling.
- Preceptor needs to be guided and supported by the nurse educators in understanding the student learning needs in a placement area to understand the different methods, of facilitating clinical learning as well as be a good assessor.

Preceptor should build interpersonal relationships through provision of guidance and support to the students in order to reduce their anxiety (Hughes & Quinn 2013:379). Sedgwick and Harris (2012:1) described in this paper demonstrate that it is imperative that nurse educators, nursing programmes, and leaders in the practice environment engage in critical reflection of the current models of clinical practice education so that programmes are able to graduate safe and competent novice registered nurses

2.4.4 The registered nurse

Bruce et al (2013:36) state that the main responsibility of the registered nurse in the unit is to ensure that the patient receives the highest quality care, and in instances whereby

the students are unable to perform such tasks they have a moral duty to ensure that they are being taught, supervised, and mentored. In the nursing unit, the pupil enrolled nurses at second year level are placed under the direct and indirect supervision of the registered nurses and are expected to provide quality care in relation to their level of study which include performing wound dressings, administering oral and intramuscular injection, observe neurological functioning of patients.

2.4.4.1 Clinical supervision role of the registered nurse

Clinical supervision is defined according to SANC R173 of 2013 as assistance and support that is extended to the pupil nurses by the registered nurse, midwife, or staff nurse in a clinical facility and the main aim being to develop them into competent and independent practitioners. Hughes et al (2013:380) describe the principles to enhance supervision as outlined by the Nursing and Midwifery Council (NMC) (2006) as follows:

- Supervision should support practice so that it can enable the registrants to maintain and improve the standards of care.
- The practitioner should be able to reflect on practice guided by a skilled supervisor.
- Ground rules should be established so that there is openness towards clinical supervision, and awareness of expectations.
- Each registrant should have access to a supervisor and each supervisor should have reasonable number of students.
- Supervisors should be prepared through training. There should be an evaluation of supervision on their skills.

2.4.5 The patient

Patients' involvement in the clinical support is essential as it provides students opportunities to experience clinical reasoning and practice clinical skills during their interaction. Students come across patients in diverse contexts throughout their education. It is reported that, however, looking across the research providing evidence about learning related to patient-student encounters discloses a lack of knowledge about the actual learning process that occurs in encounters between patients and students. It is also reported that the most striking results showed that patients took

different approaches in the encounters with students. It is mentioned that when the students succeeded to create a good atmosphere and a mutual relationship, the patients were active participants in the students' learning. If the students did not cope to create a good atmosphere, the relationship became one-way and the patients were passive participants, letting the students practice on their bodies but without engaging in a dialogue with the students (Manninen, Henriksson, Scheja & Silén 2014:1).

2.4.6 The pupil nurses at their second year level

A pupil nurse at the second year level is a pupil nurses undertaking a course SANC (R2175 of 1993, as amended) which will lead to enrolment as a nurse. Most pupil nurses commence this course when they are in late adolescence and early adulthood, therefore principles of adult learning have to be applied during their education and training. These principles include self-directedness and motivation (Mkhwanazi 2007:45).

2.4.7 Clinical learning environment

Clinical learning environment is a clinical setting wherein pupil nurses are brought into contact with patients in order to achieve specific learning outcomes related to patients' need through provision of a holistic approach that include physical, spiritual, psychological, spiritual and social support. Such an environment should be conducive in terms of support from supervisors, mentors, preceptors, and nurse educators thus fostering team spirit wherein the student feels that they belong. Student should be encouraged to use their initiatives and utilise critical thinking and judgement skills freely to integrate theory into practice (Hughes & Quinn 2013:361).

Reilly and Oermann (1992:109) assert that a supportive learning environment is characterised by an attitude of caring towards students, establishing mutual trust and respect, creating a non-judgemental different approaches, value learning, provide student freedom and encourage them to question, explore and discover. Rikhotso et al (2014:7) study revealed that some students perceived the clinical learning environment differently stating that they have been blamed for wrong actions in the wards by registered nurses, who did not guide or support them.

Hughes and Quinn (2013:386) emphasise that the nurse educator has to be aware of changes and current issues in the clinical setting. It is further mentioned that the nurse educators should evaluate their current knowledge, skills and expertise in order to be able to teach a pupil nurses in a realistic way onto how to integrate theory and practice. This could be achieved amongst the others through:

- The development of the learning environment
- Involving clinicians in the teaching at the nursing institutions

2.4.7.1 The development of the learning environment

The educator needs to be well organised in terms of planning and assessing need for clinical involvement, thus structuring how and when they can see the student and be flexible in adapting the plan to meet the needs. The nurse educator will also ensure that suitable patients with special needs are identified and theory is integrated into practice, through application of the nursing process by demonstrating admission of a patient and relating the theory of the integrated general science as well as some aspects of social science (Mashaba & Brink 1994:51).

Hughes and Quinn (2013:361) mentioned that nurse educators and clinical facilitators should be available to coordinate, and plan practice placement and allocate students to appropriate learning situation, provide them with support, and assist with advice and problem solving. The teacher and the pupil nurses are involved in a supported facilitated learning environment. This environment should incorporate caring relationships, and should be structured in such a way that it can be explored for learning to develop (Billings & Hallstead 2012:315).

According to SANC, these clinical settings should be accredited for clinical learning on conditions that it meets learning needs and practice for students. In this study, the accredited clinical setting is a private hospital accredited for the placement of pupil enrolled nurses at their second year level from the private nursing institution.

Nxumalo (2011:290) and Rikhotso et al (2014:10) in their studies revealed that there were differences between simulated skills and the actual procedures. The fact that clinical facilitators did not fulfil their roles, and they got less exposure to learning

opportunities, made them to perceive the clinical learning environment as not supported. Overpopulation of students in the clinical area was also noted as a challenge.

2.4.7.2 Involving multidisciplinary team members in the teaching at the nursing education institutions

Fitzgerald, Gordon, Katz and Hirsch (2012:6) recommended that the nurse educator should work in collaboration with other clinical practitioners in identifying and implementing the best clinical education methods to overcome challenges encountered in maintaining high quality learning environment. Introducing students to the people involved in the care of their allocated patients, for example, physicians, pharmacists and physiotherapists, when discussing needs and changes to care provides support (Twentyman, Eaton & Henderson 2006:35)

2.4.8 SANC Position on clinical support as part of clinical teaching

SANC is the body responsible for controlling nursing education within the Republic of South Africa. The body ensures the control by regulating education and training through provisions of guidelines and regulations pertaining to different training programmes.

2.4.8.1 Programme leading to enrolment as a nurse

One of the three categories of nurses trained in South Africa is the enrolled nurse, guided by the training programme (R2175 of 1993, as amended) (SANC 1993b). The specific curriculum for the enrolled nurse course includes course content, clinical training, internal and external examinations and all of these are conducted during the course of the programme. External examinations are set by the SANC for the training of this category of nurses to (Regulation R2175 of 1993, as amended) (SANC 1993b:6(1-2), 6(3) (a-d) 8(1-3); South Africa 1985 as cited by Mkhwanazi 2007:45). The enrolled nurses course is offered over a two-year certificate programme (SANC 1993b), and they function under the scope of practice SANC (R2598 of 1984, as amended).

The enrolled nursing training in Limpopo province is offered by government institution according to different districts as well as private hospitals within the geographical areas.

In this study, the focus is on enrolled nurses at their second year of study within one private hospital in the Limpopo Province. Pupil nurse refers to a person who is following a programme leading to enrolment as a nurse in an accredited nursing education institution in South Africa according to the SANC (R.2175 of 1993, as amended) (SANC 1993b).

2.4.8.1.1 Conditions for enrolment as a nurse

The conditions that are applicable to this study are as follows according to SANC (R2175 of 1993, paragraph 2(1) (a-e), as amended):

- The pupil nurse should have attained the course objectives stated in the above; regulation and should have passed examinations referred to or should have been exempted from the examination as set out in terms of the regulation relating to examinations of SANC (R7 of 1993, as amended).
- Part of the course objectives is the clinical objectives in which the pupil nurse has to be found competent in. The second year procedure includes the following: administration of medication (oral, intramuscular, suppositories, inhalations); perform wound dressings; removal of wound drains; sutures; insert urinary catheters; observation of patients' neurological functions; as well as perform electrocardiograms.
- This procedures form part of the clinical course objectives to be met for the course leading to enrolment as a nurse according to the amended SANC (R2175, of 1993, as amended) (SANC 1993b).
- The pupil nurse should have passed the examinations which should include theoretical and practical examinations, which are conducted by the nurse educator from a learning institution or nursing school (Powell 2012:34).

2.4.8.1.2 The nurse educators: key responsible people

The nurse educators are the key responsible people in the education and training of pupil nurses, in both the clinical area and the classroom. Mkhwanazi (2007) cited Mellish et al (2000:71) who indicate that nurse educators are the major role players in the professional development of student nurses, and they should therefore support the pupil nurses every step of the way. However, Mkhwanazi (2007) cited Orem (1995:199)

when mentioning that there are some events and conditions that adversely affect human development at the various stages of a lifecycle.

2.4.8.1.3 The curriculum and the course content including the clinical training

According to the Teaching Guide for the programme leading to enrolment as a nurse SANC (R2175 of 1993, as amended) (SANC 1993b), as amended, paragraph 2 on practical guidelines the following apply to the study:

- An enrolled nurse has to demonstrate an understanding pertaining to laws governing nursing such as the Nursing Act, Scope of practice and regulations.
- There should be demonstration of willingness to cooperate with other team members of the nursing profession, including co-workers and other medical professions within the health team. The pupil nurse at second year level has to cooperate and in order to learn to master skills as demonstrated by mentors.
- The pupil enrolled nurse should be exposed to clinical learning opportunities at all levels from primary, secondary and tertiary amounting to hours exceeding 2000 for both years according to their course curriculum.
- There should integration of theory into practice to ensure proper health education related to disease conditions by the enrolled nurse. There should be optimal delivery of care in a competent manner. The pupil enrolled at their second year of study has to master procedure set for the year in order to be considered safe practitioners.
- Ability to demonstrate regimen as initiated by the registered nurse should be shown by the pupil enrolled at their second year of study.
- Ability to assist during clinical investigations and procedures has to be shown.
- The enrolled nurse's course content runs over two academic years. The first year should incorporate the following subjects:

    - Nursing History and Ethics
    - Basic Nursing Care
    - Elementary Nutrition
    - First Aid
    - Elementary Anatomy and Physiology

- Introduction to Comprehensive Health Care

The following includes second year subjects (specialities):

- General Nursing Care
- Nursing Care of the Aged
- Nursing Care of Mentally Retarded Persons
- Community Nursing
- Psychiatric Nursing Care (R2175 of 1993, paragraph 6(1-2) (South Africa 1985).

General Nursing Care is the speciality that is pursued by the Private Hospital Nursing Institution in Limpopo Province.

2.5 GOALS OF CLINICAL SUPPORT

The primary purpose of clinical support is to provide students with opportunities to integrate theory they have learnt in class and practice to become skilled, knowledgeable and proficient providers of high quality nursing care.

2.6 FACTORS HINDERING EFFECTIVE CLINICAL SUPPORT PROVISION

Anarado et al (2016:140) identified major hampering factors in clinical training of students to include: incompleteness of practical procedures to be demonstrated before clinical placement, gap in accompaniment of students by nurse educators and lack of preceptors to coach them. Kaphagawani and Useh (2013:181) indicated that poor relationships with clinical staff, lack of support from educators and lack of stimulating learning opportunities are some of the negative experiences that may affect students learning.

2.7 PROMOTION OF EFFECTIVE CLINICAL SUPPORT

Twentyman et al (2006:35) outlined the strategies to assist the nurse educators and the registered nurses in fostering clinical support to pupil nurses as follows:

- Orienting the students to the unit, routine and the people they are likely to come across during their placement.
- Ensuring students have a diary or handover sheet and are allocated tea breaks with other team members.
- Encouraging students to be involved in every aspect of their patients' care. This means adjusting their role as their scope of practice allows.
- Collaborating with students, telling them why you are doing things and involving them in the decision-making and problem-solving processes.
- Role modelling positive behaviour.
- Providing the patient with quality care and encouraging the student to do the same.
- Ensuring any criticism is constructive and delivered in a way that does not humiliate or embarrass the student, providing a solution and rationale for the problem.
- Assisting learning in strategies to help the student learn and work independently and take on responsibility by recognising the value of your own skills and knowledge and be prepared to share these with the student
- Encouraging the student to ask questions.
- Making it clear what you expect of the student.
- Being patient. It is mentioned that important to remember that it can take three to five times longer for a student to complete a task than it would for an experienced, qualified professional.
- Allowing the nursing student to practise as independently as possible.
  Encouraging her or him to recognise the healthcare priorities for their allocated patient load, to develop their own time plan, deliver their care, handover and document their actions while offering appropriate prompting and constructive ideas for future improvement.

2.8 CONCLUSION

Chapter 2 presented literature review available on the concept clinical support and related concepts. SANC's views on clinical support were included and the theoretical background supporting the study was described. In the next chapter, the research design and methodology will be discussed.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter addresses the research design and methodology followed in conducting the study. The research design and methodology comprising of the population, sampling technique, data collection and analysis are addressed.

3.2 RESEARCH DESIGNS

According to Grove et al (2015:211), research design is described as a blueprint guiding the study, thus utilising maximum control over the factors that could interfere with the expected results of the study. The research design form the basis for obtaining answers to questions under study and conditions for enhancing the study integrity are also included (Polit & Beck 2012:741).The overall aim of a research design is to address the objectives of the study.

In this study the qualitative, exploratory, descriptive and contextual design was followed by the researcher to explore and describe the perceptions of the pupil enrolled nurses at their second year of study towards clinical support during clinical placement at the private hospital.

3.2.1 Qualitative approach paradigm

Paradigms are the most important model or frame of reference that is utilised in organising our observations and reasoning. Creswell (2014:6) describes a paradigm as a general philosophical position about the world and nature of researcher that the researcher brings to a study .A paradigm creates a path for focus and understanding (Babbie 2013:58). A paradigm consists of the following components: ontology, epistemology, methodology, and, methods component is explained, and then the relationships between them are explored. Every paradigm is based upon its own ontological and epistemological assumptions.

This qualitative study is based on the grounds of the naturalistic inquiry which is also referred to as constructivism.

Creswell (2014:8) and Polit and Beck (2012:723) both concur that constructivism is perceived as an approach to qualitative research. Constructivism focus is to seek an understanding of the world that people live in or work. People develop subjective meaning of their experience, and those meanings are directed towards certain things. It is further mentioned that those meanings are complex and that provides the researcher with a broader view on what the participant experienced. Broad questions including open ended question facilitate construction of a meaningful situation (Creswell 2014:8). Polit and Beck (2012:723) alluded that by asserting that constructivism paradigm embraces that there are multiple interpretations of reality and that the aim of research is to understand how individuals construct reality within their context and this is often with qualitative research. It is further stated that for the naturalistic inquirer, reality is not a fixed entity, but rather a construction of the participants. It is also indicated that it occurs in a context and there are multiple construction and all are meaningful. It is also stated that constructivism paradigm assume that when the distance between the participants and the enquirer is minimised then knowledge is maximised. It is further asserted that there needs to be interaction between the participants and the researcher so that there is an understanding of their voices and interpretations.

According to Polit and Beck (2012:14), qualitative research design is a naturalistic inquiry that places emphasis on the understanding of the human experience, as it is lived, through careful collection and analysis of subjective, qualitative materials and narrative. It is further mentioned that naturalistic tradition believe that humans have inherent complexity whereby they are able to shape and create their own experiences, with the result that ideas expected become the truth that is a combination of realities. Qualitative research is a systematic, interactive subjective approach that is conducted to describe and promote understanding of human experiences such as caring, comfort and pain and give them meaning (Grove et al 2015:67).

Streubert and Carpenter (2007:21) assert that qualitative research entails the experiences and realities of human beings rather than those of objects. Grove et al (2015:20) indicate that this design best promotes understanding of human nature, as

narration facilitates understanding of the experience, and meaning devoted to experiences. The researcher has interest in the subjective and interactive nature of this design as it allows participants to narrate their experiences; and thus enables understanding of human beings in terms of their exclusivity, holistic nature and dynamic forces. In this study, the researcher adopted the qualitative design as compatible for the study because:

3.2.2 Exploratory design

De Vos et al (2011:95) assert that an exploratory study is conducted in order to gain insight into phenomena, situation, individual or community. Exploratory qualitative research component seek to explore and give answers in different ways about how phenomena and processes occur (Polit & Beck 2012:227). The written narratives and the focus group interviews are the appropriate chosen methods for data collection. The researcher utilised written narratives guided by a grand question to explore the participant's responses. Further exploration was ensured through utilisation of the focus group interview whereby a topic guide was used. Due to the exploratory nature of the design the researcher was able to gain insight into perceptions of pupil nurses at their second year of study regarding clinical support during placement.

3.2.3 Descriptive design

De Vos et al (2011:96) assert that the descriptive designs present a picture of the specific details describing the situation, relationship or social setting and focus on the "how" and "why" questions. It is further mentioned that it seek to explore the phenomena's deeper meaning thus leading to thicker descriptions.

In this study, descriptive design enabled the researcher to explore the pupil nurses at their second year level of training, perceptions towards support during clinical placement as well as describing the perceptions of the pupil nurses. The researcher utilised the focus group interviews, field notes and written narrative to explore the perceptions towards support during clinical placement. The recommendations to enhance clinical support for pupil nurses at their second year of their study were described as well.

3.2.4 Contextual

According to Polit and Beck (2012:18), contextual research design seeks to explore and give answers into different ways about how phenomena and processes take place. The aim of the researcher is to describe and understand events within a concrete, and in a natural context as they take place (Brink et al 2012:121). The context in which the study occurred was a private hospital in which pupil nurses at their second year were interviewed to ensure that the significance of the data and social meaning has not been distorted (Molefe 2011:26).

3.3 RESEARCH METHODOLOGY

The research methodology is described as the general approach the researcher takes in conducting the research project, to some extent, this approach directs the particular tools the researcher collects, the methods and research procedures followed when conducting a study (Leedy & Ormrod 2010:12). In this study the research methodology that was followed included: population, sample and sampling, data collection and analysis, trustworthiness and ethical considerations.

3.3.1 Population

According to Fox and Bayat (2007:30), population is referred to as comprising of the total collection of all the unit of analysis (members or elements of a population) about which the researcher requires to reach distinct conclusions. In this study, the population refers to all pupil nurses at their second year level who are enrolled with the SANC's regulation relating to the programme leading to enrolment as a nurse (SANC R2175 of 1993, as amended). The pupil nurses under the study belonged to a private nursing institution (NEI) and were placed at a private hospital for clinical practice. The accessible population composed of twenty members.

3.3.1.1 The research setting

The research was conducted at a private hospital in the Limpopo Province which is situated in the Capricorn District Municipality, within the city of Polokwane. The private hospital is selected because it is an accredited clinical placement area for a Private Nursing Education Institution. In the private hospital the pupil nurses are under the supervision of the nurse educators and registered nurses to fulfil their clinical expectations.

The nurse educator has to fulfil the accompaniment role in the clinical setting. The pupil nurses are normally allocated in a clinical learning environment for a stated period, to work all shifts in order to meet the learning needs at the particular level of training. The pupil nurses at their second year are counted fully as workforce in the private hospital. This implies that pupil nurses at their second year have to fulfil their learning and working roles. The registered nurses and nurse educators' provision of clinical support can influence the pupil nurses clinical learning. Therefore the significance of studying the perceptions of pupil nurses at their second year level towards clinical support at the private hospital is proper.

3.3.2 Sample and sampling

A sample is described by Grove et al (2015:511), De Vos et al (2011:360) and Brink et al (2012:131) as a process whereby a subsection or component of the population is selected and considered for actual inclusion in the study). The researcher often set parameters before selecting a sample through utilisation of inclusion or eligibility criteria (Moule & Goodman 2014:291). The aim is to get a sample that is as representative as possible of the target population.

The researcher utilised non-probability, purposive sampling to choose the study participants from the accessible population. In non-probability sampling, the researcher judges and chooses those participants that know most about the phenomenon and are able to clarify and narrate the differences within the information offered (Grove et al 2015:250). Polit and Beck (2012:735) describe non-probability method of sampling as that sampling where participants are selected from the population utilising non-random

procedures. The descriptive and exploratory component of the research qualifies for the method to be utilised in this study.

Berg and Lune (2012:52) describe purposive sampling as a process whereby the researcher utilises their special knowledge or expertise about the phenomena to select subjects who represent the population and have information about the phenomena studied. Polit and Beck (2012:279) assert that during purposive sampling the researchers make use of the information that they possess regarding the sample members to make a decision about the participants to be chosen. It is further stated that the decision could be based on the knowledge that the participants have regarding the study. The researcher chose the pupil enrolled nurses at their second year level who qualified according to the inclusion criteria mentioned below. The researcher was of the opinion that second year level students have better knowledge and understanding of the dynamics of clinical support when allocated in the clinical setting for practice. They probable possess rich first-hand information and were therefore able to share their perceptions regarding the phenomena better (Brink et al 2012:141).

Brink et al (2012) cited LoBiondio-Wood and Haber (2010:222) who assert that the sample population includes both the inclusion and exclusion criteria. In this study, the inclusion and exclusion criteria were outlined as follows:

3.3.2.1 Inclusion criteria

- Participants should have been enrolled with SANC's regulation relating to the programme leading to enrolment as a nurse SANC (R2175 of 1993, as amended).
- Participants should be pursuing studies at the Private Nursing Education Institution and are placed at a private hospital in the Limpopo for clinical learning.
- Participants should belong to second year January 2015 and June 2014 intake and even those who were repeating second level.

3.3.2.2 Exclusion criteria

An exclusion criterion is defined as those potential participants excluded from the study (Brink et al 2012:131).

- Pupil nurses at second year of study belonging to 2015 June intake, as they had just commenced with the course and not yet been exposed to all practical demonstrations and second year clinical placement.

3.3.3 Sample size

According to Brink et al (2012:143), the sample size of qualitative study is determined by data saturation. Grove et al (2015:371) assert that in qualitative research, the sample size is determined by the quality of data obtained from the participants, occasion, situation and documents sampled versus the size of the sample. Botma et al (2010:200) alluded that the sample size is determined by the two criteria intended for 'enough' referring to sufficiency and saturation. The sample size consisted of twelve participants. Polit and Beck (2012:742) define saturation as the point that is reached when there is no more new data emerging during data collection.

In this study the sample size was centred on the purpose of the study. Data saturation was reached on the twelve participants who were selected from twenty pupil enrolled at their second level of study. These chosen participants had adequate theoretical and practical exposure and were placed at the private hospital during this period. Two focus group interviews consisting of four and eight participants were conducted until saturation of data was reached. Probing and reflective skills were used during the study to enable participants to share rich base data in a meaningful manner.

3.3.4 Data collection

Data collection is described by Grove et al (2015:502) as identification of subjects and the detailed, systematic collection of information (data) relevant to the research purpose, specific objectives, questions or hypothesis of the study. The process involves a detailed and systematic collection of information from the target group with the purpose of addressing the aims and objectives of the study. Brink et al (2012:56) explain that it is vital that the researcher is familiar with the data collection methods to be utilised, know their advantages and ensure that all data collected is relevant to the study. Qualitative research utilises several data-collection methods, such as interviews, observation, and written documents and records (Grove et al 2015:310).

The data was collected by means of written narratives and focus group interviews and field notes on twelve participants. According to Polit and Beck (2012:53), qualitative researchers collect rich data from the participants' personal experiences and emotions of the research phenomena utilising narrative descriptions. De Vos et al (2011:360) indicate that focus group creates a clearer understanding on how people think and feel about an issue.

Participant`s responses were written down and tape recorded as agreed with them and transcribed verbatim to simplify data analysis. The researcher also took field notes during the focus group interviews on observable behaviours (non-verbal cues) from the participants (Creswell 2007:139). The following three phases, namely: preparatory data collection, data collection phase and the post interview phase will be discussed.

3.3.4.1 Preparatory phase

3.3.4.1.1 Recruitment techniques and retention of research participants

Recruitment is a process involving identifying, accessing and communicating with potential study participants who are representative of the target population (Grove et al 2015:374). The researcher proceeded with data collection following ethical clearance to conduct the study that was obtained from the University of South Africa Higher Degrees Ethics Committee, and written permission from the private hospital group. There needs to be careful planning with respect to participants, the environment and questions that need to be asked. A detailed plan is also needed to ensure logic and to identify any shortcomings (De Vos et al 2011:364). Two weeks before the actual group the researcher arranged to meet initially with the potential participants. The main aim of the initial contact was to establish rapport and trust with the participants. In addition the information session date and the actual interviews dates had to be confirmed. The researcher got permission from the hospital management to utilise the boardroom. According to De Vos et al (2011:364), provision of a well-focused environment for the participants is important to ensure a successful outcome. A list of potential participants to be assigned to the three groups was already obtained by the hospital learning and development consultant voluntarily.

The researcher met with the potential participants who represented the pupil nurses at their second year level. In the session the researcher informed them about the study, the significance and their involvement in the study. The date, time and venue of the information session were confirmed and the hospital management were informed about them as they were going to take place in the hospital. The information session was scheduled a week after the initial contact session. De Vos et al (2011:366) explain that one week before the actual group the researcher should give the participants the confirmation letters.

A former colleague employed by a local university as a Head of department in Nursing Science Department was identified by the researcher to act as a research assistant. The research assistant has completed her doctoral degree. The main role of the researcher assistant was to operate the tape recorder, take the field notes and handle environmental conditions and logistics, attends to unexpected interruptions and also plays an important role during the post meeting analysis of the sessions (De Vos et al 2011:366). The research assistant was informed about the dates of the information session. The researcher and the research assistant discussed the proceedings and the logistics prior to the information session and the exploratory interview. There was testing of the tape recorder and also spare batteries arranged in case needed. The grand tour question was posed and the further probing question on the topic guide list were clarified and confirmed beforehand (see Annexure F).

3.3.4.1.2 Information to the participants

The researcher met with the participants in the hospital boardroom a week following the initial contact session in order to provide them with all the information needed and to also attend to areas where they seek clarity. The researcher utilised the list and confirmed the dates, times and venue of the interviews. Participants were briefed on the purpose and significance of the study, and time was allocated for clarification of questions from the participants. The researcher assured the participants of privacy and confidentiality. They were informed about the consent form to be signed to ensure their willingness to participate. Participation was voluntarily and participants could withdraw from the study anytime they wish to. The presence of the research assistant and her roles was explained and participants were assured confidentiality as she also signed the

confidentiality clause. The utilisation of the tape recorder was explained to them. The information letters were given to the participants to go through them.

De Vos et al (2011) cited in Morgan and Krueger (1998:41) explain that a researcher conducting interview should be experienced or trained as an interviewer before conducting the interview as the quality of data relies on the communication and interpersonal skill. The researcher has been trained as facilitator and is extensively involved in facilitation at the private nursing institution and is also assisting in conducting some of the workshops in the private hospital. The research assistant is also trained as a facilitator and is quite experienced and is involved in such programmes at her area of employment.

The venue where the interviews were to be held was prepared in advance at the hospital boardroom.

3.3.4.1.3 The exploratory interview

According to De Vos et al (2011:394) and Polit and Beck (2012:195), exploratory interview refers to a study undertaken by the researcher involving few respondents with the same characteristics as those of the main study with the aim of testing questions, establishing suitability of study methods, procedures, and instruments and modifying them to ensure quality interview as well as establishing costs and time expected. In the study the exploratory focus group population consisted of three members. According to Polit and Beck (2012:195) an exploratory interview consists of small scale or trial run utilised to test methods to be utilised in larger studies. It was conducted a week before the main focus group. The three pupil nurses at their second year were afterwards excluded from the main study.

During the exploratory interview a brief introduction consisting of the purpose of the study, that is, to explore and gain more insight into the perceptions of pupil nurses at their second year regarding clinical support at a private hospital in the Limpopo Province, South Africa was explained.

The exploratory interview was of great importance as the researcher was able to identify if the questions were understood by the three pupil nurses at their second year. In

addition to that the problems that were experienced during data recording such as participants speaking at the same time were identified and corrected before the main focus group. Streubert-Speziale and Carpenter (2011:39) assert that there are several authors who agree with the challenges of recording data ranging from recording to transcription. During the exploratory interview other lessons learnt included the challenges on time needed to transcribe data. This assisted a lot as more time with regard to transcribing notes was allocated for the main focus group and it was transcribed immediately after recording. The researcher identified that the participants needed more clarity on concepts such as perceptions especially before attempting to answer and also some of the questions on the topic guide list were not easily understood and that helped in the sense that the researcher was able to rephrase them. The exploratory interview also revealed that the questioning technique of the researcher indicated that few questions were leading and such was corrected before the main interviews. The other benefit was that we could estimate the time to correctly plan for the interviews to follow. The researcher also noted from the recordings that there was some domination by one participant over the other participants. This also benefited the researcher to take note and always encourage participation from all the participants. Streubert-Speziale and Carpenter (2011:38) also highlighted that the major disadvantage of focus group is groupthink caused by dominance by stronger members.

3.3.4.2 Data collection phase

3.3.4.2.1 Data collection methods

The following methods of collecting data namely; written narratives, focus group interviews and filed notes are discussed below:

Written narratives

- **Definition of written narratives**

Written narratives are described as information which can be obtained through having conversation with the participants through diaries and notes thus providing rich descriptions of each participant's emotional state (Polit & Beck 2012:53). In this study it

was obtained through written notes. It was conducted as a once off reflection of the research phenomena and the data were included during thematic analysis.

- **Motivation for selecting written narratives as a data collection method**

According to Polit and Beck (2012:53), qualitative researchers collect data that is rich in participants' personal experiences and emotions of the research phenomena utilising narrative descriptions. Streubert-Speziale and Carpenter (2011:40) assert that many researchers opt for written narratives as they provide an individual with time to think about what they would like to share. The researcher wanted to provide the participants with more time to think about the phenomena under study and that they could relate it according to how they encountered it.

- **Written narratives technique application**

In this technique, the researcher engaged two groups of pupil enrolled nurses at their second year of study. The same groups also participated in the focus group interview. The first group comprised pupil enrolled nurses at their second year of study first intake (January) eight in total, and the second group being second intake (June) four in total. This took place on the first day of the week after the exploratory interview. The researcher met with the first group of participants at the hospital boardroom. A comfortable suitable venue and necessary equipment's such as boardroom, table and chairs were arranged in a circle, note book and pens, extra note papers for written narrative were provided. The significance of conducting the research was highlighted to encourage participants to be truthful and honest in data to be shared. The researcher sought to explore and gain more insight into the perceptions of second year pupil enrolled nurses at their regarding clinical support at a private hospital in the Limpopo Province, South Africa. The presence of the research assistant was clarified again.

The participants were made aware of the written narrative as the first method of data collection and that they will also be exposed to focus group interview. Field notes were also mentioned that they will be taken during the focus group interview. They were informed that they will commence with written narratives which may take ten to twelve minutes following written consent. Written informed consent was obtained voluntarily from participants.

During the process of written narrative, each participant was provided with a notepad and a pen and on the overhead projector screen the following was projected:

> "What are the perspectives of pupil enrolled nurse at their second year of study regarding clinical support during clinical placement at the private hospital?"

The participants were allowed to write down their views on the topic as indicated on the displayed question. It took them twenty minutes to complete writing and upon completion, the papers were collected by the researcher and were safely stored under lock and key and the researcher was the only person having access to them. The data was incorporated into the thematic analysis of data.

Focus group interview

- **Definition of focus group interview**

The data collection method mostly used in qualitative research comprises focus groups. Focus group interviews is an interview that provide the researcher with an opportunity to interview and observe a group of participants together thus stimulating a discussion about topic at hand. It can be conducted in structured, semi-structured, or unstructured interviews. The researcher gets an opportunity to interview a number of participants grouped together at the same time and do that in a systematic way (Babbie 2013:349).

- **Motivation for selecting focus group interview as a data collection method**

Focus groups provide a clearer understanding of how people think and feel about an issue (De Vos et al 2011:360). It is further asserted that when utilising focus group as a data collection method, the researcher creates an atmosphere of trust and tolerance whereby the participants freely share their views, perceptions, concerns, experience and desires with no pressure exerted on them.

Babbie (2013:349) and De Vos et al (2011:361) allude that focus groups offer the following advantages:

- This method provides for capturing of real- life data in the social setting
- They are utilised as self-contained method in studies which they serve as the main source of data
- It is flexible
- Results are obtained soon
- It is affordable
- Face validity is high

- **Focus group interview technique application**

In this study, the researcher also utilised focus groups to explore the perceptions of pupil enrolled nurses at their second year of study towards clinical support at a private hospital in Limpopo Province. The researcher planned the focus group considering the participants, the questions to be asked and the environment. It is further noted that it is important that the researcher explain the main aim of the research so as to get rich data from the participants (De Vos et al 2011:364).

The researcher engaged the same two groups of pupil enrolled nurses at their second year of study that were exposed to the written narratives. The focus group took place on the same day as the written narratives. It was conducted shortly after the written narratives. The first group comprised pupil enrolled nurses at their second year of study first intake (January) eight in total, and the second group being second intake (June) four in total. Babbie (2013:349) noted that a focus group interview is one qualitative data collection method where groups are interviewed. It is further asserted that in a focus group about five to twelve participants are brought together and are engaged in a guided discussion about a given topic.

The interview sessions were held at an arranged boardroom based in the clinical facility which provided a relaxed atmosphere.On the day of the interview, the researcher ensured that the environment is comfortable and all equipment's are accessible and in good working order. The boardroom temperature was cool and lighting adequate. Necessary equipment's such as boardroom table and chairs were arranged in a circle, note book and pens, audio tape recorder with spare batteries as well as bottled drinking water and glasses were organised. The sign indicating "meeting in progress" was

displayed on the boardroom door to limit interruptions. The following procedure was followed:

- A brief introduction consisting of the purpose and objective of the study, which is to explore and gain more insight into the perceptions of second year pupil nurses regarding clinical support at a private hospital in the Limpopo Province, South Africa was explained.
- Consent was was already obtained during the written narrative data collection conducted earlier from potential participants and they were reminded of their right to withdraw from participating in the study when feeling uncomfortable as they have a right to self-determination (Brink et al 2012:35) (see Annexures D and E).
- The presence of the research assistant was clarified again and the already obtained consent during the written narrative data collection.
- Ground rules were set and agreed upon which included no utilisation of cell phones, and to give each other opportunity to speak and to speak audibly and everyone to participate fully (Grove et al 2015:1371).
- The researcher and the assistant handed out name tags and requested each participant to select a code that will be utilised as a means of identification during the recordings interview thus ensuring confidentiality (Grove et al 2015:107).
- The audio tape recorder was utilised during both sessions and field notes were taken and participants were observed for non-verbal ques (De Vos et al 2011:335).
- An assistant researcher also helped as a back-up and assisted in taking notes, operated the audio tape recorder and kept order. Streubert-Speziale and Carpenter (2011:39) assert that there are several authors who agree that there are challenges of recording data ranging from recording to transcription.
- Polit and Beck (2012:495) described bracketing as a process of holding back any preconceived ideas, opinions and beliefs that the researcher may have about the phenomena under study. In this study, bracketing was ensured through writing down aside any ideas that could influence neutrality and constitute biasness. The researcher entered the field with an open mind and wrote down her preconception in some way so that she is aware of them, so that is able to listen to the perspectives of others.

- The researcher utilised this central question: “What are the perspectives of pupil enrolled nurse at their second year of study regarding clinical support during clinical placement at the private hospital?”
- The researcher subsequently utilising a topic guide list comprising of open-ended questions and listen to responses without showing any emotions.
- The researcher was patient during the interview in order to give the participants an opportunity to answer the questions.
- It is asserted that the most important skill of interviewing is good listening skills, free from interrupting participants. The researcher refrained from talking a lot to allow participants to answer the questions. The researcher utilised minimal verbal and non-verbal ques and sought clarification on information provided.
- The researcher utilised simple language and clarified where needed.
- The researcher probed to follow up the participant’s responses with subsequent questions from the participants remarks. Polit and Beck (2012:310) describe probing as one of the facilitation skill utilised by the researcher during the interview to elicit more useful information from the research participants. The following types of probing questions was utilised “You mentioned there was no supervision over practical procedures you were carrying out-what do you mean by supervision over practical procedures?”
- Paraphrasing which is a skill applied whereby the researcher clearly express the idea by repeating the response of the other participant in another manner to ensure if the response was understood the same way (Grove et al 2015:184).
- After all tape recordings, the participants were asked to reflect on the session and the researcher summarised and clarified and any additional data coming up was handwritten. All the information was safely stored to ensure confidentiality.
- The researcher ended the sessions and reminded the participants that recommended guidelines will be utilised to enhance a supportive clinical environment during pupil nurses’ placement.

Field notes

- **Definition of field notes**

Field notes are generally written notations about what the researcher observes during data collection and these notes are included during data analysis (Streubert-Speziale & Carpenter 2011:42). De Vos et al (2011:359) refer to the process of taking field notes as a process of taking complete and accurate notes of what is taking place and writing down own view during the interview and observation. Field notes taken by the researcher may include observations, what was heard, seen or said and the experience as narrated by the researcher (Streubert-Speziale & Carpenter 2011:43).

- **Motivation for utilising field notes during data collection**

The importance of considering the critical points during note taking is described by Field and Morse (1994:79-82) as cited in De Vos et al (2011:359) as being to reduce loss of data, get a quiet place to write; record sequence events in the order that they occurred; allocate enough time to complete the notes.

- **Field notes technique application**

The researcher explained the process of taking field notes during the interview to the participants and a signed voluntary consent was confirmed by the researcher on the tape recorder. In this study, the researcher wrote down expressions and emotions and any information of significance in order to capture all that took place. Field notes were secured in a safe place and only the researcher had access to them. The safety of the recorded information was insured by keeping them in a safe place only accessible to the researcher and identifying it not utilising real names.

3.3.4.3 Post-interview phase

Debriefing session was be held immediately after the session with the assistant to confirm if the participant's meanings are understood and the researcher and the assistant agreed that the meanings were interpreted the same. Peer scrutiny was

ensured by a co-coder who is an experienced colleague in qualitative data analysis (see Annexure F).

3.3.5 Data analysis

According to Grove et al (2015:85) and Polit and Beck (2012:557), data analysis is a rigorous process involving organising data, including interview transcripts and field notes so that the research questions are addressed and meaning is derived. In this study, data analysis was done simultaneously during and after data collection. Tesch's inductive, descriptive coding technique (in Creswell 2009: 185-190) quoted in Botma et al (2010:223) was utilised adhering to the process below:

The voice recorded data was transcribed verbatim. The researcher read through the verbatim transcript to get the whole sense of the interviews and familiarised herself with data. Ideas that come to mind were written down. The researcher selected the shortest, top of the file and most interesting transcript, reread each and differentiated between meaning units and wrote down any ideas that come to mind again. Coding and categorising began as soon as data collection had begun. Coding was used to organise the data into themes and subthemes. Categorising was also used through the use of manual analysis whereby the researcher reviewed all recorded information that the researcher has obtained during the course of the data collection. Similar themes were established and relationships amongst the themes were compared. The researcher made a summary of the themes and sub-themes identified before sending to the independent co coder. Once the co-coder had completed the independent coding, common themes and sub-themes of the independent coder and the researcher were identified and summarised. The identified themes will be discussed in detail in chapter 4. The researcher ensured that the context of the research and the research.

3.3.6 Ethical consideration

When human beings are utilised as study participants, care must be exercised to ensure the protection of their rights (Polit et al 2012:150).

3.3.6.1 Approval

The researcher obtained ethical approval from the Ethics Committee of the University of South Africa (UNISA) with project number HSHDC/390/2015 (see Annexure A).

3.3.6.2 Permissions

The process of obtaining written permission from the clinical institution was channelled through the Employee Relations Office, Hospital Manager, Nursing Manager and Human Resources of the private hospital, the General Manager training of the institution and the private hospital group research committee (see Annexures B and C).

The purpose and objectives of the study were explained to the participants, and upon agreement to participate a written consent was obtained (see Annexures D and E).

3.3.6.3 Self-determination and informed consent

This principle explains that human beings are self-directed, and are capable of controlling their actions. This refers to that the participants can voluntarily decide to participate in the study without fear of prejudicial treatment. This includes that people have the right to refuse to give any information, ask questions and withdraw from the study. They cannot be coerced into the study (Polit et al 2012:152). All the participants were briefed and given information about one week before the process of data collection to read and allowed an opportunity to decide voluntarily whether to participate or not. The researcher informed the participants of the nature and purpose of the study; that participation was voluntary, and that they were free to withdraw from the study if not feeling comfortable during the study. In the study possible barriers for self-determination may include the pupil nurses under study being uncomfortable but not able to say no or withdraw nor ask questions due to fear of causing any harm in their relationship with the researcher. The participants were informed of their right to participate voluntarily or not participate in the study and that they are not coerced to participate in the study. They may withdraw if not feeling comfortable during the study and they can ask for clarity if having any questions. They were assured that there is no prejudicial treatment that may occur following their decision. The researcher also assured them of their right to privacy, confidentiality, self-determination, and fair treatment. This information assisted those

interested to make a mindful decision before giving informed consent for participations by signing informed consent forms (Polit & Beck 2010:122). The participants were assured that the research results would be communicated to them (Polit & Beck 2010:123).

3.3.6.4 Privacy and confidentiality

Privacy is described as the freedom an individual's has to decide on the time, amount and general circumstances under which personal information will be shared with or withheld from others (Grove et al 2015:105). Based on the right to privacy, participants have the right to assume that the data collected is kept confidential (Grove et al 2015:106). Confidentiality was ensured by allocating a code instead of their names during recordings. The participants were informed that the information gathered during recordings will not be distributed or shared with anyone except the people that are directly involved in the study. They were also informed that the voice recorder will be erased and all the transcribed notes will only be made available to the independent coder.

3.3.6.5 Justice

Justice refers to being fair to everyone and not giving preference or discriminating some participants over others. Being fair also involves that the need of the participants come first before the researchers needs including the objectives of the study. In assuring justice there would not be any exploitation of the participants grounds of religion, race, age, sex, sexual orientation or class (Moule & Goodman 2014:59). The researcher ensured that all pupil nurses at their second year of study qualifying could they be male, female, White, African, young and older are included in the study. The needs of the participants came first.

3.3.6.6 Beneficence and non-maleficence

Moule and Goodman (2014:60) refers to beneficence as the principle of "doing good" for both the research participant and the people. In this study the pupil enrolled nurses perspectives will be best understood and the gaps concerning clinical support will be addressed so that they are supported in becoming proficient practitioners in rendering

safe patient care thus benefiting the society at large. Beneficence is also referred to obligation of the researcher to minimise harm and maximise benefits. Human research should be intended to yield benefits. This principle is based on the right to freedom from harm and discomfort. The researcher needs to be sensitive and cautious for any such risks that might occur (Polit et al 2012:152). During the focus group interview the researcher utilised a grand tour question and upheld this principle by sensibly structuring the probing questions per individual accordingly. Non-maleficence refers to the duty not to inflict any harm on participants including psychological, emotional, physical and social. There was no anticipated harm in this study to be disclosed to the participants. The researcher facilitated debriefing by giving the participants the opportunity to ask questions, and asked to say how they felt about the interaction (Brink et al 2012:36). Scientific honesty suggests that the researcher has ethical responsibility associated with the conduct and reporting of research. The researcher stayed honestly within the research plan as pre-planned.

3.3.6.7 Measures to ensure trustworthiness

Scientific rigor in qualitative studies, according to Grove et al (2015:68), is described as the degree to which the identified meaning represent the perspectives of the participants precisely. Trustworthiness refers to validity and reliability or objectivity in research. Measures to ensure trustworthiness of the study evaluate whether the findings reflect the participants' experience and not the researcher's perceptions. The four criteria for establishing trustworthiness, namely: credibility, dependability, conformability and transferability were applied in the study (Polit & Beck 2012:584).

3.3.6.7.1 Credibility

This criterion involves evaluating whether the findings are credible from the perspective of the participants and contexts in the study (Polit & Beck 2012:585). In this research, credibility, according to Polit and Beck (2012:585), was ensured by member checking, peer review and literature control.

- Member checking as described by Moule and Goodman (2014:406) is described as a process whereby the participants are involved in verifying the meaning of the researcher, verifying the analysis. This was done on the spot during the focus

group interviews through probing to ensure participant's meanings were understood and in those instances the transcripts were read back to them to clarify if understood correctly and the information was verified as correct.

- Peer scrutiny was ensured by a co-coder who is an experienced colleague in qualitative data analysis.
- The researcher also referred to literature for literature control.

3.3.6.7.2 Transferability

Transferability refers to the degree which the results of qualitative research results are applicable in other settings (Polit & Beck 2012:585).

- Transferability was ensured by providing a thick, full description of the research method and design of the study.
- Transferability was ascertained through purposive sampling in order to get first hand perceptions of the participants. The main objective was to understand unique situations and not to generalise findings. Purposive sampling was used to select the sample with an aim of seeking a maximised range of specific information for ensuring transferability (Brink 2012:173).

3.3.6.7.3 Dependability

This refers to stability of the data to account for the ever changing context within which the research occur (Polit & Beck 2012:585). In this study, it was ensured by reporting all process within the study in detail that is the research plan, method and implementation and capturing all changes that would have happened.

3.3.6.7.4 Conformability

This refers to the state that the results could be verified by others to be objective and the findings are reflective of the participants and the study itself (Polit & Beck 2012:585).

- This was ensured through triangulation and reflexivity. A second researcher, experienced in qualitative data analysis, was a co-coder and there was a consensus between the researcher and the co-coder regarding the findings.

- Focus group interviews were audio-taped, transcribed to verbatim and field notes were written and records were available for audits trials.
- The findings were supported from literature. Data collection ceased because of the saturation.
- Frequent debriefing sessions were held with the supervisors to critique the data.
- Narrative description data collection method were utilised whereby the pupil under study will be asked to write down their perception with regard to the clinical placement at a private hospital.

3.4 CONCLUSION

This chapter outlined the research design and methodology. The researcher utilised focus groups interviews and narratives as data collection method. Participants were briefed about the topic to be able to collect data. The independent coder and the researcher analysed the data. In the next chapter data analysis will be fully described.

CHAPTER 4

RESULTS, INTERPRETATION AND DISCUSSION

4.1 INTRODUCTION

This chapter presents the data analysis, interpretations and the results. Polit and Beck (2012:557) describe data analysis as a method of organising data, comprising of interview transcripts and field notes so that the research questions are addressed and meaning is derived.

The purpose of this study was to explore the perceptions of the second year pupil nurses towards clinical support during clinical placement at the private hospital in the Limpopo Province, South Africa. From the results of the study necessary recommendations would be made to facilitate clinical support of the pupil nurses second year during placement.

4.2 MANAGEMENT AND ANALYSIS OF DATA

Burns and Grove (2005:88) explain that in qualitative studies data analysis occurs concurrently with data collection through the process of collecting, managing and interpreting data. De Vos et al (2015:502) and Polit and Beck (2012:562) assert that data analysis is the technique involving reducing data through converting it into smaller, and more manageable sections,organising and giving it meaning.

The results of data collected were through focus group interviews, field notes and written narratives from twelve participants which were tape-recorded and transcribed verbatim. The participants' privacy and confidentiality were protected by the researcher through allocating a code instead of their names. All the participants were asked a grand tour question during the written narratives. During the focus group interview the grand tour question was asked again followed up by subsequent open-ended questions on the topic guide list and flexibility was permitted. Probing questions were asked to obtain clarity on participants' responses when necessary. Field notes were also collected during the focus group interview. The written narratives took about twenty to twenty five minutes. The focus group interview lasted about an hour and twenty minutes

to an hour and thirty minutes. Tesch's inductive, descriptive coding technique (in Creswell 2009:185-190) quoted in Botma et al (2010:223) was used utilised and themes and subthemes emerged during data analysis. The focus group verbatim, the written narratives and the field notes were all included in the thematic analysis.

4.3 FINDINGS OF THE STUDY

4.3.1 Demographic profile of participants

Twelve participants were interviewed. Three participants were males and from the age groups of 20-29 years and twelve were females from the age group of 20-40 years. All the twelve participants had experienced clinical support during their placement at their second year of study from a period ranging between 6 months to 11 months at a private hospital at the Limpopo Province, South Africa. Malapela (2014:67) cited Thupayagale-Tshweneagae Rapaeye (2009:65) when asserting that the nursing population is dominated by female population hence in this study. The study had no intention of exploring these variables with regard to clinical support.

Table 4.1: Demographic profile of participants

CRITERION	CHARACTERISTICS	FREQUENCY	PERCENTAGE
Gender	Female	12	80.0
	Male	3	20.0
Ethnic Group	White	2	13.0
	North Sotho	7	46.6
	Tsonga	3	20.0
	Venda	2	13.0
	Ndebele	1	6.6
	Seswati	0	0.0
	Zulu	0	0.0
	Tswana	0	0.0
	South Sotho	0	0.0
Ages	20-24	6	40.0
	25-29	4	26.6
	30-34	4	26.6
	35-40	1	6.6
Level of training	Pupil enrolled nurses at their second year	15	100.0

4.3.2 Themes and subthemes

Five major themes emerged from the data. The results of data collected were through focus group interviews, field notes and written narratives from twelve participants which were tape-recorded and transcribed verbatim. Each theme is discussed in detail with relevant direct verbatim response from participants as indicated in tables with borders written in italics. The written narratives and field notes were included in the thematic analysis. There is no interference with regard to grammar in the quotation and they are supported by literature control to endorse the results of the study. Table 4.2 presents the themes and subthemes.

Table 4.2: Themes and subthemes reflecting perceptions of the pupil nurses at their second year level towards clinical support during clinical placement at the private hospital in the Limpopo Province, South Africa

MAIN THEMES	SUBTHEMES
1 Cognitive domain: an integral part of theory practice integration	1.1 Knowledge related to the concept clinical support 1.2 Lack of cognitive support to enhance theory practice integration
2 Psychomotor domain enhance mastery of clinical skills	2.1 Reflection on clinical skills performance 2.2 Uncertainties experienced during performance of patients' care activities 2.3 Clinical support: a team effort 2.4 Psychomotor support leads to realisation of goals
3 Clinical support not sustaining the caring component	3.1 Provision of knowledge related to caring 3.2 Communication attributes in clinical support 3.3 Negative attitude versus positive attitude in clinical support 3.4 Clinical support apparently not sustaining confidence 3.5 Several adaptive mechanisms used by pupil nurses to learn and cope
4 Challenges encountered	4.1 Tales and personal distressing situations perceived related to clinical support 4.2 Support versus lack of support from the unit manager, mentors and the nursing staff 4.3 Support versus lack of support from nurse educators 4.4 Resource utilised during clinical support 4.5 Allocated patients' activities not related to level of training

MAIN THEMES	SUBTHEMES
5 Self-directedness of pupil nurses	5.1 Setting own clinical learning goals and objectives 5.2 Taking responsibility to involve allocated mentors, tutors and ward staff members to teach 5.3 Support in management of time: a key element during clinical learning 5.4 Evaluation of outcomes

4.3.3 Theme 1:1: Cognitive domain an integral part of theory practice integration

The participants indicated that there is a gap in cognitive support provision and that influence their theory practice integration. Cognitive according to Meyer (2008:150) is defined as the development of thinking skills. Bastable (2014:436) define cognitive support as the thinking domain which involves acquisition of knowledge, development of pupil nurses's intellectual abilities, thinking processes capacities, and understanding.

Cognitive support can be accomplished by utilising different teaching strategies. Hughes and Quinn (2013:388) assert that techniques such as teaching on a one basis, hand over, reports, case conferences, clinical rounds, reflective, diary, learning contracts, critical incidents technique, and teaching a motor skill can develop the cognitive domain. Mashaba (1994:272) postulate that different approaches should be utilised to facilitate transfer of knowledge to practice due to the fact that people and situations changes at all times.

Molefe (2011:82) asserted that students need the continuous presence of the registered nurse to assist in the integration of theory into practice. The subthemes will be discussed separately quoting directly the participant's responses and literature concerned will also be reviewed.

4.3.3.1 Subtheme 1.1: Knowledge related to the concept clinical support

The participants had knowledge regarding the concept clinical support, however their definition varies. According to the participants the definition of clinical support during focus group interviews is marked by such utterances:

Participant (Part) E: *"Clinical support includes having someone in the clinical learning environment to provide support and guidance at all the times."*

(Part) A*: "I think it is when students are given an opportunity to learn from practical experience from those that had the experience and learn to integrate theory into practice."*

(Part) C: *"I think the clinical support is offered by creating a safe environment with enough equipment and stock and the students are orientated towards what is expected of them and they have enough tutors and the students take responsibility into their learning."*

(Part) F*: "My understanding is that we must be able to work in clean and safe environment with enough equipment's and security."*

(Part) D: *"it is the support which is provided through in-service training."*

Part C*: ''Clinical support refers to learning in practice whereby personnel are free to teach and supervise in practical work and are also ready to give you feedback constructively."*

Part G*: "Clinical support is when someone guides you in a caring manner, shows interest and accepts you as an individual in order to develop your full potential."*

Clinical support knowledge as extracted from the written narratives indicated that the participants had a clearer understanding of the clinical support as they described it as offering guidance to pupil nurses through exposing them to teaching so as to integrate theory into practice. It is fully acknowledged globally that clinical support forms an integral part within nursing education in developing nursing students into proficient practitioners. However the findings in this study indicated that clinical support develops its real meaning according to how people perceive it within their specific environmental setting. The concept clinical support was explained by participants in different ways. It was perceived as a concept incorporating other concepts to give it its full meaning. Some participants seemed to have a clearer knowledge of what clinical support is.

Majority of them mentioned most of the identified concepts in describing clinical support and only a few mentioned less.

Clinical support is therefore individual and context specific. The findings of this study in defining clinical support therefore support Joolaee et al (2015:1) argument when stating that although support has been described in a number of ways and is one of the major needs of nursing students during clinical education, its definition according to literature is not clear. Joolaee et al (2015:1) further assert that no consensus exist on the concept clinical support.

The purpose of clinical support is understood to be the same across different institutions, but its specific definition varies. The researcher opinion as well as the pupil nurses might not be precisely the same, but the important fact is that the application should meet all the criteria set.

According to Mellish et al (2000:76) support is described as being there for a person and availing oneself when needed. In nursing support can be described as a specific component of the caring process and it has often being correlated to strengthening and adapting. According to Gidman, McIntosh; Melling and Smith (2011:1), students support means to get the clinical expertise, are able to record evidence and resolve personal instances. Support is defined by Stanhope and Lancaster (1992:684) as to sustain a person’s right to make a choice and to act on the choice.

Mkhwanazi (2007:12), in her study, defined support as being there for individuals accepting them, and being non-judgemental and open to communicate in order to help them identify and manage the challenges they come across and thus enabling them to tranced from the lowest to the highest levels of nursing education.

Clinical support was understood by the participants as the provision of guidance and support by an experienced caring person who accepts and understands the needs of the student and assists them in realising their clinical goals so that they can become proficient providers of care.

4.3.3.2 Subtheme 1.2: Lack of cognitive support to enhance theory practice integration

There is some knowledge with regard to understanding the concept theory practice integration, however, there are some concerns that there is a gap in applying it. Knowledge with regard to theory practice integration is marked by utterances such as:

Part A: *"Theory practice integration is an approach of bringing together on what you had learnt from theoretical components to correlate into practice."*

According to Meyer and Van Niekerk (2008:81), theory practice integration implies that a leaners abstract reasoning and critical analytic skills are stimulated so that they can be able to take independent evaluation of the scientific content. It is further mentioned that a neat, logical nursing care approach following principles should be demonstrated.

With regard to application of theory into practice, the participants stated that there is a gap. This is confirmed by one of the utterances quoted below:

Part E: *"The registered nurse will say please go and perform the procedure; for example, giving of medication, and promise that she will come and see you, and I will perform the skill as I am asked but not confident that it is correct as I am not being observed or supervised."*

Part B: *"They just point at you that there is an electrocardiogram there to be performed, thereafter there is no one interested in seeing the results or showing you how to interpret it."*

Mogale (2011:39) explain that in theory practice integration the students should be given an opportunity to be guided and supported into becoming professionals who are accountable.

The proposed model for integration of practice according to the Nursing Education Stakeholders (NES) Group (2011:2) suggested that the student should be equipped with knowledge from all the discipline, be incorporated in identifying the problem and

understand how to react towards the needs of the patient. In contrary to the suggested proposal Blanchette (2015:27) study indicated that the the registered nurses seem to be experiencing role overload due to shortage of resources and possibly excessive demands from their workplace which had a negative influence on theory practice integration. Another study by Moagi and Maritz (2013:259) also highlighted a gap in clinical support as it explain that due to poor integration of theory into practice student experience uncertainties, anxiety as well as feelings of abandonment when exposed to health care settings.

The nurse educator supportive role in the psychomotor, cognitive and affective development of the students is of paramount importance in the integration of theory into practice (SANC R425, February 1985:2).

Botma et al (2012:1) explain that the challenges of students in relation to theory practice integration stems from that some nurse educators are not utilising teaching strategies that promotes transfer of learning, and the student readiness to learn is not assessed in applying newly constructed knowledge. Moonaghi, Mirhagi, Oladi and Zeydi (2015:3) emphasise that a clinical educator being a promoter of theory practice integration add much value through relating what is learned into routine practice. Furthermore, the study adds that promotion of effective communication by the unit manager and the team as well as nurse educator plays a major role in theory practice integration

4.3.4 Theme 2: Psychomotor domain enhance mastery of skills

The participant stated that they are not being exposed to observe how the clinical procedures are carried out by experienced people. They also indicated that there is a lack of supervision when carrying out clinical procedures. They indicated that some members of the multidisciplinary team members like physician do supervise them as well and that encourages them, however, they feel that the support they expect should be a team effort. They also indicated that if they get supervised they will be able to get competent in time thus realising their objectives.

The psychomotor domain is referred to as the skill domain. This involves the utilisation of fine and gross motor skills in carrying out the procedure. However the other two domains namely; affective and cognitive are required in the execution of the

psychomotor skill. The affective is integrated as it adds value or worth in relating to the patient in the skill performed whilst cognitive will instil the principles, processes and relationship in carrying out the process (Bastable 2014:457).

4.3.4.1 Subtheme 2.1: Reflection on clinical skills performance

The participant stated that there is lack of exposure to observation when clinical procedures are carried out by experienced people. This is confirmed by one of the utterances quoted below:

Part B: *"It is challenging to get the opportunity to observe an experienced person performing the clinical procedure as you are also allocated number of duties to carry out at that specific period."*

The participants also verbalised that they relied on observing other personnel members performing their expected competency skill without participating, because they were not given a chance to practice their expected roles. This is confirmed by one of the utterances quoted below:

Part D: *"Observing most of the time and making myself available even if I do not perform the skill at least give me an idea of how to go about."*

They also indicated that they also experience a gap in being supervised when carrying out clinical procedures. This is confirmed by one of the utterances quoted below:

Part G: *"Even though we get exposed to all the procedures expected in the second year level we face challenges of no one supervising us as they are busy with the nursing unit routine."*

Part A: *"If there is procedure for second year for example, ECG, they may call you to come and perform the procedure but there would be no one to supervise you".*

Part F: *"They will only expose you to do second level procedures when they are not coping in terms of workload and you end up giving medication alone without supervision."*

Part E: *"Sometimes, it becomes difficult to be observed as you are allocated with an enrolled nursing assistant".*

Part G: *"I think it is very frustrating because you know why you are in the wards but you don't have ample time to perform procedures because you are considered as a workforce."*

Croxon and Maginnis (2009:241) assert that where students are been provided with an opportunity for "hands on" experience it promotes skills mastery.

4.3.4.2 Subtheme 2.2: Uncertainties experienced during performance of patients' care activities

The participants expressed uncertainties due to the fact that they are not sure whether they are performing the procedures correctly or not. This is confirmed by one of the utterances quoted below:

Part A: *"We do not know if we are doing it the right way due to lack of support or business of the nursing unit".*

Part B: "*Even shortage of staff is a problem they don't give us any attention, not at all."*

Part H: "*I think it's a bit overwhelming, because you are trying to learn new things, but feel intimidated to go forward e.g. giving of an injection first time as there is no one to be over your shoulder."*

The participants also made mention of the fact that they are not trusted by the registered nurses so that makes them not to be allocated second year procedures, thus leaving them without any room to practice and they end up being uncertain of their skills. This is confirmed by one of the utterances quoted below:

Part D: "*The thing is that they do not trust us because we are not yet there, so they don't allow us to do certain things."*

A study conducted in Iran by Moonaghi et al (2015:4) stated that there have been many studies conducted on uncertainties with regard to expected roles of pupil nurses and accomplishing their needs. However, they suggest that for pupil nurses to be certain of their goals, they need nurse educators' support and good communication as well as preceptors in the clinical learning environment fulfilling their education function role.

4.3.4.3 Subtheme 2.3: Clinical support: a team effort

The participants indicated that the clinical support received is not a team effort because few members are involved whilst others are not involved at all. Such utterances were made:

Part C: *''Team approach is when all the nurses senior to me and registered nurses including the nurse educators ,physiotherapist, dieticians and doctors, work together and promote clinical teaching of students so that the goal of providing quality care to the patient can be reached."*

Part B: *"Simply I can say you learn the hard way as you perform the procedures such as perform Electrocardiogram alone. Technically you can perform this procedure but you are not sure if the results are normal unless you get a chance to be with the doctor to explain to you, it is then that you can relate these results to the previous one performed without interpretation."*

Bruce et al (2011:256) assert that clinical practice area brings on challenges to the students due to its complexities and dynamics. All the stakeholders involved in clinical teaching should be clear of their expected roles on clinical support.

4.3.4.4 Subtheme 2.4: Psychomotor support leads to realisation of goals

The participants indicated during focus group interviews that some unit managers assisted in them realising their goals, although most mentioned that the realisation of goals was not made possible. Such utterances were made:

Part A: *"I really learnt a lot in one unit because the unit manager was always making a follow up on our learning objectives and encouraging her personnel to take us along when performing procedures such as giving of medications and wound care."*

Part A: *"The unit manager will keep on enquiring about our goals and that motivates us to also work towards realising them as the personnel of that unit will be supporting us."*

Part A: *"The only way to realise your objectives is to come during your off duty days as you are not seen as workforce and you are able to practice and be assessed on your nursing skills."*

It was also noted from field notes as attested by the following:

Part A: Giggling and sighing *"it feels that we might not reach that goal".*

It was indicated that there needs to be support from nurse educators, registered nurses including the unit managers as well as some members of the multi-disciplinary team to support the students in achieving the learning goals. Croxon and Maginnis (2009:240) cited Chapman and Ord (2000) who postulate that learning opportunities depend on staff willingness to include the participants as team members in order for them to realise their objectives.

4.3.5 Theme 3: Clinical support not sustaining the caring phenomena

The participant indicated that they understand that support is a caring process. They asserted that supportive environment is marked by respectful communication, feeling of acceptance, feelings of security and confidence. However, they indicated some lack in

the caring component which makes them not feel empowered but had to develop adoptive way to thrive and be able to realise their goals.

4.3.5.1 Subtheme 3.1: Provision of knowledge related to caring

Participants had an understanding of caring as a component of clinical support and provided the following quotes:

Part A: *"Support as a caring phenomena does not only mean to teach clinical skills, but it provides us pupil nurses with care , and in turn we can be able to demonstrate that care back to the patient."*

Part A: *"Supportive caring attitude means one should be accepted as an individual, be able to be clarified through open communication and in turn will feel confident in pursuing one tasks."*

Joolaee et al (2015:1) in their study indicated that nursing students needs a nurturing care that will make them to feel a sense of worthiness and respectability there by expanding their clinical abilities.

4.3.5.2 Subtheme 3.2: Communication attributes in clinical support

The participants indicated that communication that is respectful indicates a caring attitude. However their encounters with regard to communication were not as such. Such utterances attest to this:

Part A*: "When the nursing staff label us, calling us with names such as "medico or hazards" that demoralised us."*

Part E*: "It really hurt me when I was requesting a registered nurse to come and observe me performing a clinical procedure, and she said to me registered nurse is not "yoghurta" which she was referring to type of a sweet. That meant to me that she is very important and expensive. Such utterances really discourage us to seek for clarity in pursuing our tasks."*

Joalee (2015:1) indicated that appropriate communication, that is respectful none humiliating is regarded by the student as strengthening the relationship between them and their mentors.

4.3.5.3 Subtheme 3.3: Negative attitude versus positive attitude in clinical support

The participants indicated that some members of the nursing team including the unit manager, the nurse educator and some registered nurses display a positive attitude of accepting them whilst other registered nurses display a negative attitude towards them. Such quotes attest to this:

Part A: *"There are some unit managers who will welcome you into the unit and orientate you and assure you that she is available when you encounter problems, and will continue to guide and correct in a positive way."*

Part F: *"There was in one unit where a registered nurse introduced herself to me and told me I am your mentor and she was available, guiding and teaching me."*

Part D: *"In some nursing units there is no form of orientation given to you even if you are being exposed for the first time. You are expected to adapt the very first day and with little answers provided when you pose a question."*

Part E: *"If you make a mistake you will be shouted in front of patients and subordinates and that makes one feel humiliated and afraid to attempt to perform our clinical procedures as expected."*

Joalee 20154) in their study found that when students are accepted as human beings, treated respectfully and allowed to make mistakes, feel comfortable with a sense of belonging.

4.3.5.4 Subtheme 3.4: Clinical support apparently not sustaining confidence

The participants reflected that there is a gap in terms of direct support during task execution to foster confidence. This is confirmed by some of the utterances quoted below:

Part B*: "You are not going to say I am confident and I am competent in doing this, but you are going to say I have learnt this."*

Part A: "*Yes I only feel confident and competent in what I am doing once the tutors evaluated me."*

Part A*: "If there was a bit more of a definitive line saying you are here to be a student, you are going to learn and practice, versus you are here to make money, so you have to work."*

Part G: *"I think it is amasing how things that we were taught at the NEI differ so much with that happening in the units because they are very different."*

Moonaghi et al's (2015:4) study highlighted that the educational atmosphere in the clinical learning environment is very crucial. It is further mentioned that the head nurse and staff are responsible to play an important role in creating an effective critical learning and good practices in the clinical learning environment that foster support.

4.3.5.5 Subtheme 3.5: Several adaptive mechanisms used by pupil nurses to learn and cope

The participants expressed that they had to adapt and find ways of coping without clinical support. This is confirmed by some of the utterances quoted below:

Part G: *"In our second year, I think it is much easier for us to survive because we know what to expect from certain individuals in certain wards."*

Part A: *"Yes they have thickened our skin."*

Part B: *"Sometimes it is important to take lack of support and supervision as a challenge and say I can try by all means to realise at least two or three objectives."*

Part B: *"Sometimes we resorted to work independently of the mentors."*

Reilly and Oermann (1992:109) assert that a supportive learning environment is characterised by an attitude of caring towards students, establishing mutual trust and respect, creating a non-judgemental different approaches, value learning, provide student freedom and encourage them to question, explore and discover.

4.3.6 Theme 4: Challenges encountered

The participants encountered challenges related to clinical support leading to distress. The distress was associated to lack of supervision when participants carried out procedures pertaining to second year of which some were invasive without supervision. The educators provided demonstrations but the challenge was that opportunities would prevail for practice in the units but there was no supervision. This frustrated students as they were not sure that they are getting towards competency. Other issue related to the feelings of distress is that when they are allocated to a specific section of the unit, one cannot go to another side even when there are rare procedures available for observation or practice. The student nurses were mostly frustrated when they were allocated auxiliary nurses' procedures which limit their opportunity to practice second year procedures. Other factors such as understaffing leave them with less time to practice. Being considered as workforce also limits opportunities for practical learning. Other frustrations were distrust by nursing staff and labelling them, calling them names such as "medico or hazards" which demoralised them.

4.3.6.1 Subtheme 4.1: Tales and personal distressing situations perceived related to clinical support

The participants reflected by means of telling tales with regards to their experience on clinical support. The tales comprised feelings of distress during clinical placement related to exposure to a level lower than their level procedures and being left alone.

This made them to feel unsafe as they were not sure that the skills practiced are done correctly to avoid harm to patients and they could neither interpret the results. Codes such as the following were uttered:

Part A: *"Many a times you are allocated first year level procedures like perform vital signs, and you are not exposed to second year procedures as they say we are performing them slowly but the fact is we are not getting any supervision to be deemed competent in them."*

Part A: *"Sometimes the opportunity is there but you cannot take advantage of it."*

Part A: "*Even though the procedures were demonstrated at the nursing education institution we struggle to get supervision in getting competent in those procedures due to business of units. Moreover, when allocated at one side you cannot access the procedures if they are available on the other side."*

Part A: *"The other challenge that causes distress is understaffing."*

From field notes the following was captured:

"That situation really pained me" participants eyes tearful and appear distressed.

Bruce et al (2011:254) indicate that the methods of clinical learning include guiding, support, observe care rendered, and make critical judgment of that by providing corrections and guidance through assessment, sensitivity to the needs of students and role modelling of professional conduct for the pupil nurses to become a competent practitioner.

Rikhotso et al's (2014:1) study also point out that failure to support and guide the nursing student may lead to high turnover and absenteeism.

4.3.6.2 Subtheme 4.2: Support versus lack of support from the unit manager, mentors and nursing staff

The participants indicated that from their experience when they get placed in the units where the unit managers are supportive, the whole team also become motivated to support the pupil nurses.

The following transcripts from interviews confirm this:

Part A: *"From my experience a unit manager who is more positive about learning will motivate staff and help student realise objectives."*

According to Bruce et al (2011:257), the unit manager has to teach, supervise and mentor students. Opportunities such as teachable moment should be utilised and the unit manager should delegate and ensure that the registered nurses teach the students.

When the unit managers display positive attributes towards students' that will positively influence her unit and all the team members will be willing to teach. This is confirmed by one of the utterances quoted below:

Part G: *"Some unit manager even showed us how to write the care plans".*

Some participants indicated that there are few instances in some units where you are allocated a mentor and mentorship occur. This is confirmed by one of the utterances quoted below:

Part D: *"There was only one unit where I came across a registered nurse and she introduced herself as my mentor and she dedicated most of the time supporting me by showing me how to practice the nursing skills and provided encouraging feedback."*

However, the participants also indicated the following with regards to mentors: there is no mentoring as mentors are existing in name only, thus unable to observe, teach and assess them. They are not allocated on the same shifts with them. Mentors attitude

towards teaching is not perceived as positive. Mentors are not competent to supervise them. This is confirmed by some of the utterances quoted below:

Part G: "*You do not have a person you can say it's your mentor. On daily basis you get allocated a new mentor and that mentor is always having a lot on her plate to have time for you."*

Part G*: "I think it's only on paper that they have written that this is your mentor and they never find time as they are always busy."*

Part D: *"They are only aware that they are your mentors at the end of placement when they have to sign your monthly report."*

The lack of support was also attested during written narratives whereby the participants expressed concern that due to lack of supervision from mentors and preceptors they are left uncertain for a period of time without knowing whether they are progressing in mastering the skills. The participants expressed concerns that they will not be able to say they are competent and confident in the second year procedures due to lack of observation during the process of practising to become competent.

In this study, field notes also assisted in capturing the non-verbal as well as the facial expressions. The following were observed during data collection:

"I strongly agree with that" the participant nodding the head as well in affirming the other participant input on lack of support from the mentors.

The support in the form of mentorship assists pupil nurses to progress through developmental phases taking place during their training as well as in education. According to Hughes and Quinn (2013:371), a mentor is described as a qualified and knowledgeable staff member of the clinical setting who agrees formally to offer educational and personal support to a student during the duration of placement. This form of support may take place in the form of teaching, guiding, counselling, evaluating and supervising.

An article entitled: Mentoring African American Nursing Students: A Holistic Approach (2012:3) concluded that mentorship has power in improving student retention, growth, helps students to acquire complex issues. In the same article, students were quoted stating that a mentor is someone who shows enthusiasm, friendly, approachable; demonstrate patience and understanding coupled with great sense of humour.

The five recommendations as presented in the above-mentioned article pertaining to developing a strong effective mentor-mentee relationship includes dedication, honesty and truth, mutual trust and respect, positive and caring attitude as well as appreciation of mentee as a whole person. In this study, mentorship seems not to take place as referred above. Setati's (2013:91) study revealed that mentorship was experienced positively by some students although some did not. From those challenges that existed that will motivate staff to improve and enhance mentorship more.

From the participants' responses on support offered by nursing staff, they made mention of mentors more. This could be probably because according to them every registered nurse in the clinical setting is regarded as a mentor. Nevertheless, the role of the registered nurses in the units seems not to be undertaken fully. Bruce et al (2011:36) state that the main responsibility of the registered nurse in the unit is to ensure that the patients receive the highest quality care, and in instances whereby the students are unable to perform such tasks they have a moral duty to ensure that they are being taught, supervised, and mentored. In the nursing unit, the pupil enrolled nurses at second year level are placed under the direct and indirect supervision of the registered nurses. They are expected to provide quality care in relation to their level of study including perform wound dressings, administer oral and intramuscular injection, observe neurological functioning of patients.

There were few instances where collegial support was mentioned and in contrary some of the participants responded that they also learn from enrolled nursing assistant who are a level lower than the participants. This creates role confusion because according to Hardy and Conway (1988:7), research and theory on roles have on many occasions proven that the normative role expectation in relation to different positions evolve around the personnel interacting with one another. Mashaba and Brink (1994:318) postulate that nursing education individuals are positioned according to hierarchical structures composing of different levels, and it could range from institution, regional and

national and these is in relation to their social relation and the expected outcome of their interactions. The new and young members of the nursing profession need to learn on how to take on the new roles and adapt so as to conform to expectation for continuity of the profession (Mashaba & Brink 1994:319). In this proposed study, the role that pupil nurses at their second year of study have to acquire is based on their interactions with other members of the nursing team. This was done according to their hierarchical positions could be from nursing manager, registered nurse, enrolled nurses and auxiliary nurses, as these interactions will help them develop meaning and thus be able to enact the expected roles.

4.3.6.3 Subtheme 4.3: Support versus lack of support from nurse educators

The participants overemphasised through written narratives that lack of support in terms of nurse educators who are few impede tutor-student ratio in terms of support. The participants also indicated during focus group interviews that there is support from nurse educators in terms of demonstration, assessment, and sometimes practice of procedure but the challenge is that there are few given the number of students needing accompaniment. This is confirmed by some of the utterances quoted below:

Part G: "*There is support but their support is minimal we are a large number."*

Part B: "*I will give credit to the tutors for their effort is just that there are challenges that we meet, outweighs the results we should see on the pupil nurses."*

Part E: "*The educators are supportive and they motivate us to do our work in time."*

Part D: "*And even if we come across like emotional stress they really support us emotionally privately and confidentiality."*

The nurse educators are the key responsible people in the education and training of pupil nurses, in both the clinical area and the classroom. In this study, although these roles of nurse educators are performed, the tutor-student ratio impeded support. Data were collected during the period of participants' placement at the NEI. The total number of student nurses registered at the NEI was about fifty four with a total number of three

educators including the Head Nurse. The educators had to facilitate classes as well as other administration responsibilities as well as do accompaniment which may cause an imbalance in terms of support as the participants mentioned a gap in mentoring.

From the participants' responses, it was deduced that they acknowledge the support they get from their educators but the challenge remains that the tutor student ratio impedes support. The dominant role of the educators was highlighted in 4.1 as well as the implications on student support.

Mashaba and Brink (1994:51) reiterate that some colleges go to an extent of stipulating parameters with regards to time, and the question remains if really the amount of time spent with the pupil nurses is really productive. Crotty (1998) was cited by Mashaba and Brink (1994:51) when endorsing that there is still less amount of time spent on clinical teaching compared to time taken by nurse educator liaising and counselling students.

The scope of the nurse educator includes student and staff-related activities. The student-related activities includes student accompaniment, demonstrating nursing skills, supervision and guidance, formulation of clinical objectives, role modelling professional behaviour, helping in critical thinking, problem solving, assessment of pupil nurses and overall guidance and support of pupil nurses. Some of the clinical staff-related activities are development of staff through in-service training, communication and liaison with the units. The nurse educator has to ensure that the student-related activities always surpass the clinical staff related ones (Mashaba & Brink 1994:51).

4.3.6.4 Subtheme 4.4: Resources utilised during clinical support

The participants also reflected during focus group interviews that due to understaffing learning opportunities are taken away. They also reflected the fact that they are allocated as workforce to substantiate shortage of staff. The human resources needed to support performance of tasks expressed by participants was a great need for mentorship and preceptorship as alluded in subthemes 4.1, 4.2 and 4.3. This is confirmed by one of the utterances quoted below:

Part A: *"I think due to a problem of not having enough nurses in general then the understaffing takes away the learning opportunities."*

Part B: *"Support from registered nurses and mentors are minimal due to challenges of understaffing."*

Part B: *"I think if we could have nurse educators, who are fully based in the clinical field, then we will always have somebody on our side."*

The material resources were perceived as adequate to enhance support. Such quotes were uttered in confirmation:

Part G: *"With regards to equipment's we are having all we need to perform our tasks."*

However, few from the written narratives stressed that there should always be enough resources in terms of stock, equipment and nurse educators and staff to offer continuous support and that will help them realise their objectives. Rikhotso et al's study (2014:4) revealed that there was lack of support related to inadequate clinical equipment which hindered staff and student in rendering of safe patient care, which in the case of this study is adequate thus increasing support.

4.3.6.5 Subtheme 4.5: Allocated patients' activities not related to level of training

The participant expressed that they are allocated as an enrolled nursing assistant and so they continue to perform skills at pupil enrolled nurse first year level thus lessening their chance of practicing their expected roles. This is confirmed by one of the utterances quoted below:

Part C: *"When I am in the unit and I am allocated as an auxiliary nurse I do not get an opportunity to practice skills that will lead me towards a proficient enrolled nurse."*

According to the Teaching Guide for the programme leading to enrolment as a nurse SANC (R2175 of 1993, as amended) (SANC 1993b), as amended, paragraph 2 on practical guidelines the following apply to the study:

The pupil enrolled nurse should be exposed to clinical learning opportunities at all levels from primary, secondary and tertiary amounting to hours exceeding 2000 for both years according to their course curriculum. There should be optimal delivery of care in a competent manner. The pupil enrolled at their second year of study has to master procedure set for the year in order to be considered safe practitioners.

4.3.7 Theme 5: Self-directedness of pupil nurses

Self-directedness of pupil nurses involves being familiar with their learning needs and that include practical procedures demonstrated and in the clinical learning environment. The participants expressed their preparation starting at the NEI with demonstration in simulation laboratory and at clinical sites as well. They added that after demonstration they practiced the skills prior to placement. The participant reported that they always wrote down objectives and present them to the unit manager on arrival in the unit so that they may be assisted in realising them. They further verbalised that they encountered problems with realising them because most of the mentors do not get to the point of supervising them. Some of the participants explained that if one wrote those objectives and prioritise them and communicate them to the unit manager with a positive attitude they were normally achieved.

4.3.7.1 Subtheme 5.1: Setting own clinical learning goals and objectives

Most participants reported that they set goals, and others stressed that if the objectives are better communicated with the unit managers then they get achieved. This is confirmed by some of the utterances quoted below:

Part B: *"Firstly you need to plan your goals and objectives."*

Part A: *"What I have just discovered with planning your objectives, you approach your unit manager for those specific objectives so that you priorities and can be supported."*

Most of the participants reported of the challenges such as workload and business of the units. This created a problem of them not being observed while carrying out tasks thus leading them to be uncertain of their nursing skills.

Burns et al (2006) as quoted by Bruce et al (2011:255) highlight the following principles of preceptorship:

- Preceptors should plan the clinical setting properly and be familiar with the students' expected period of stay, their objectives, the type of patients the student might need and the records involved.
- Student goals should be looked into on the first day and uncertainties' clarified.
- Follow-up and assist in attainment of goals and role modelling.
- Preceptor needs to be guided and supported by the nurse educators in understanding the student learning needs in a placement area to understand the different methods, of facilitating clinical learning as well as be a good assessor.

4.3.7.2 Subtheme 5.2: Taking responsibility to involve allocated mentors, tutors and ward staff members to teach

As mentioned in subtheme 5.3, the participants do involve the mentors by showing them objectives but the reality expressed was that they do not get the opportunity to be observed by them due to business of units. This is confirmed by some of the utterances quoted below:

Part A: *"I just want to highlight on how important it is for ones evaluation to be observe and be given feedback on your skills before final assessment."*

Part C: *"If you do not know how to do something and refer to someone who knows and is competent, in the future you can be a good mentor to someone."*

According to Carlson and Ewan (2009:526), preceptors should incorporate different techniques and strategies such as development of trust, encourage atmosphere of letting students think out of the box, establish a safe learning environment by being close to the students to demonstrate, evaluate them, and give them feedback.

4.3.7.3 Subtheme 5.3: Support in management of time: a key element during clinical learning

From the interviews, most of the participants mentioned that they get to be assessed on their free time meaning tea times or when they are not on duty. They mentioned that it is very convenient for them to practice and be assessed as they would not be in the way for the unit's routine. Utterance such as the following was uttered:

Part A: *"We had to come in on our off days to do the procedures in the wards where they are available".*

Part A: *"Hmm you know, wanting to complete and finish the course − "laughing" sarcastically about it. We just felt that we have to come and do it."*

Franklin (2013:34) indicated that there should be development of unit model of supervision of students whereby students will be given attention in terms of on-going support and education. In that regard pupil nurses will also have adequate time to rest.

4.3.7.4 Subtheme 5.4: Evaluation of outcomes

The participants verbalised that it is important for them to be evaluated so that their skills can be measured. They made mentioned that even though they set goals and objectives and still practice what frustrate them is that there is no one to observe them practicing before evaluation. So they verbalised that they lack important continuous feedback, and the only time that they are assessed is when the nurse educators does their final assessment. Codes such as the following were uttered:

Part A: *"I don't want the nurse educator to be the beginning and the end of my competency."*

Meyer and Van Niekerk (2008:150) describe assessment as having a value of establishing the extent of skill mastery and to plan further to assist the student if necessary. It is further mentioned that the three dimensions which should to be

assessed comprise of the cognitive, psychomotor and affective domain of learning which offers a more holistic picture of students' performance or students' abilities upon specific competencies.

4.4 SIGNIFICANCE OF THE RESULTS

The data gathered from the study clearly demonstrate how pupil enrolled nurses perceived their clinical support within the context of the study and how it may influence their learning towards completing and qualifying as competent enrolled nurses. The findings of the study indicate substantial challenges in the clinical area and these challenges were impacting on their acquisition of skills of pupil enrolled nurses at their second year level of training. This makes it impossible to declare them as competent practitioners in perusing their nursing skills. This study also add factors such as the active role of the nurse educator to play a dominant role by creating and facilitating a positive clinical support through communication; have adequate educators or preceptors to participate in clinical accompaniment and listen to the students' reflection on the clinical support, as well as preparing the pupil nurses to know about the dynamics of the clinical learning environment and ensuring that they take responsibility towards their learning. Mashaba and Brink (1994:318) cited Biddle and Thomas (1996:17) when describing role theory as the study that focus on examining processes and phases of socialisation, individual interdependence, structuring of social positions, processes dealing with conformity and sanctioning, as well as division and specialisation of labour. The theory was chosen on the basis that it focuses on interpersonal, interaction and interpretation of behaviour within the institution whereby roles are performed by role players. It also addresses the point that role players' performance of a role can be predicted, and also focus on how certain behaviours can be anticipated (Hardy & Conway 1988:17). The role theory has to be incorporated in socialising the pupil nurses into their new roles through effective mentorship and preceptorship programmes.

4.5 CONCLUSION

This chapter discussed the findings and the results of the study that was conducted on 15 participants. The purpose of the study was to explore and describe the perceptions of the pupil nurses at their second year level towards clinical support during clinical placement at the private hospital in the Limpopo Province, South Africa. Data were

triangulated utilising a variety of methods to explore the perceptions of the pupil nurses at their second year level towards clinical support during clinical placement at the hospital under study inclusive of focus group interview, written narratives, as well as field notes. From the data, five themes emerged. From the data, five themes emerged. These include: Cognitive domain an integral part of theory practice integration, psychomotor domain enhance mastery of clinical skills, clinical support a not sustaining the caring phenomena, challenges encountered and self-directedness of pupil nurses. Out of the five themes, subthemes were developed which were substantiated by literature control to confirm the facts and findings within this study. In the last chapter, the discussion of conclusions, implications, recommendations as well as limitation to the study will be discussed.

CHAPTER 5

RESEARCH FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

Chapter 4 discussed the data analysis, interpretation, and the findings on the participants' perceptions towards clinical support at their placement area. Themes and sub-themes were identified and the research findings were fully integrated with relevant literature. This chapter provides research findings, conclusions, recommendations and limitations of the study based on the themes discussed in chapter 4.

5.2 RESEARCH DESIGN AND METHOD

The researcher followed a qualitative, exploratory, descriptive and contextual design to explore and describe the perceptions of the pupil enrolled nurses at their second year of study towards clinical support during clinical placement at the private hospital. The qualitative research design is a naturalistic investigation that puts emphasis on the understanding of human experience as it is lived, through careful collection and analysis of narrative and subjective qualitative materials (Polit & Beck 2012:14). Grove et al (2015:20) indicate that this design best promotes understanding of human nature, as narration facilitates understanding of the experience, and meaning devoted to experiences. The researcher has interest in the subjective and interactive nature of this design as it allows participants to narrate their experiences; and thus enables understanding of human beings in terms of their exclusivity, holistic nature and dynamic forces.

- The accessible population for this study comprised of the pupil nurses at their second year level who are enrolled with the SANC's regulation relating to the programme leading to enrolment as a nurse (SANC R2175 of 1993, as amended) and are placed at a private hospital in the Capricorn district in Limpopo Province. In this study, the researcher utilised non-probability, purposive sampling to choose the twelve of the pupil nurses at their second year level who are enrolled

with the SANC's regulation relating to the programme leading to enrolment as a nurse (SANC R2175 of 1993, as amended). Data were collected through written narratives and focus group interviews whereby field notes were taken guided by a grand tour question stating: "What are the perspectives of pupil enrolled nurse at their second year of study regarding clinical support during clinical placement at the private hospital?"

This was followed up by question as per topic guide list. Chapter 4 discussed the data analysis using Tesch's inductive, open coding technique (in Creswell 2009:185-190 quoted in Botma et al 2010:223).

5.3 FINDINGS OF THE STUDY

The research findings indicated that the pupil nurses at their second year level predominantly perceived lack of clinical support. The lack was attributed to inadequate educators for accompaniment, registered nurses' uncaring attitude and not fulfilling their mentorship role. The findings also revealed that the participants were not self-directed towards their learning. Those challenges influenced the performance of student negatively as they were only found competent on the second or third assessment. The other concern was that they were not proficient upon course completion and thus needed extra time to adapt fully into the enrolled nurses role which is a concern on the safe rendering of quality care to the patient. The following five themes emerged:

Table 5.1: Main themes

• Cognitive domain: an integral part of theory practice integration
• Psychomotor domain enhance mastery of clinical skills
• Clinical support not sustaining the caring component
• Challenges encountered
• Self-directedness of pupil nurses

THEME 1: Cognitive domain: an integral part of theory practice integration

The study revealed that most participants perceived lack in cognitive support provision and that influence their theory practice integration.All the participants had an understanding of what clinical support is although described differently but the approaches to provision of clinical support were incorporated. The subthemes were:

- Knowledge related to the concept clinical support
- Lack of cognitive support to enhance theory practice integration

Subtheme1.1: Knowledge related to the concept clinical support

The participants explained clinical support in various ways. It was not perceived as an isolated concept, but the core was the same. Clinical support was understood by the participants as the provision of guidance and support by an experienced caring person who accepts and understands the needs of the student and assists them in realising their clinical goals so that they can become proficient providers of care.

Subtheme1.2: Lack of cognitive support to enhance theory practice integration

The participants explained that there is lack of cognitive support and that influence the theory practice integration adversely. They indicated that although they receive theory in class, the critical component of correlating that into practice is not exercised. Rikhotso et al (2014:1) asserted that theory practice integration is the theory learnt in class being integrated with clinical experience and supplemented through teaching by staff.

Integration of theory and practice depends on the nurse educator. The nurse educator should be able to identify the theory mastered in class and all other science to be integrated within the clinical learning environment. The nurse educator needs to spend more time in practice areas being physically present in order to support the students to correlate theory into practice (Bruce et al 2011:254). Even though it is clearly outlined that the chief person responsible for theory and practice integration is the nurse educator, however, the clinical instructors, ward registered nurses and unit managers should supplement and compliment this role.

Functional perspective of the role theory focuses on duties and expectations an individual has interact with others adopting and acting their roles. Omer et al (2016:54) in their study on “roles and responsibilities of nurse preceptors: perception of preceptors and preceptors” emphasised that adopting both functional and symbolic interactionism approach develops students in terms of professional skills, knowledge, and attitude at the clinical learning environment through an interactive process.

THEME 2: Psychomotor domain enhance mastery of clinical skills

The participants explained that they are unable to master the skill of performing procedures at second year level as they do not have support in terms of mentors taking on their role. Meyer and Van Niekerk (2008:103) explain that psychomotor attainment enhances professional skills. It is further mentioned that actions involving reflex actions, physical abilities, perceptual skills and nonverbal skills plays a greater role in the execution of the psychomotor skill. The subthemes were:

- Reflection on clinical skills performance
- Uncertainties experienced during performance of patients’ care activities
- Clinical support: a team effort
- Psychomotor support leads to realisation of goals

Subtheme 2.1: Reflection on clinical skills performance

The participants indicated that they do not get an opportunity to observe and practice the procedures with experienced people. That leads them to carrying out those clinical procedures on their own. The other factors mentioned are that even though the clinical procedures are in abundance they are performed at a faster rate and not the same way as they were demonstrated to them. They also get disadvantaged as they mentioned that they are mostly delegated to do first year procedures as they are told that they are slow and not competent to perform the second year procedures. This is contrary to the main aim of them being placed at the clinical area. There should be optimal delivery of care in a competent manner.

According to the Teaching Guide for the programme leading to enrolment as a nurse SANC (R2175 of 1993, as amended) (SANC 1993b), as amended, paragraph 2 on practical guidelines the following apply:
The pupil enrolled at their second year of study has to master procedure set for the year in order to be considered safe practitioners and in this study this is not fully implemented.

According to Du Toit and Le Roux (2014:93), role taking is explained as capacity to take role of other. In the study role takes places through pupil nurses at their second level imitating other role models behavior through interaction and observation to understand the rationale behind the behaviour. This is called social learning. According to the interpretation of the results pupil nurses at their second year level are not able to enact the role due to lack of supervision in mastering the skill.

Subtheme 2.2: *Uncertainties experienced during performance of patients' care activities*

The participants expressed uncertainties due to the fact that they are not sure whether they are performing the procedures correctly or not. They also mentioned that they are considered as workforce which limits their chances of practising the expected procedures.

The participants also made mention of the fact that they are not trusted by the registered nurses so that makes them not to be allocated second year procedures, thus leaving them without any room to practice and they end up being uncertain of their skills. The student should actively participates in learning and, as such, would ultimately gain necessary knowledge, attitudes values, attitudes and mastery of clinical skills. Planning is mandatory in the form of programmes together with the student (Mogale 2011:17).

Blanchette (2015:27) describes role stress as when social structure causes demands on the individual which are difficult or impossible to meet. In this study the pupil under study experience role stress as they are uncertain of whether they are providing the patient activities correctly due to lack of supervision from the mentors.

Subtheme 2.3: Clinical support: a team effort

The participants explained that they perceive doctors offering additional support. They indicated that the team members should collaborate with one another towards a common goal, which is the provision of quality care. Zarshenas, Sharif, Molazem. Khayyer, Zare and Ebadi (2014:435) support the notion that experience of social connectedness and cooperation among nursing and other multidisciplinary team members leads to sense of being valued, foster self-confidence and that enhance the socialization process of the student.

Professional socialisation as a process whereby norms, values and way of viewing the profession are transmitted in order that the member can view himself as a member of the profession, thus assists the member to fully adjust into the professional world. Each and every professional group has values, so student nurses also learn values which are guidelines for caring and conducting one in the acceptable manner during delivery of health care service. It is further noted that Role theory emphasises the importance of preparing the students to enable them to face a particular job expectation (Lai & Lim 2012:32).

Subtheme 2.4: Psychomotor support leads to realisation of goals

The participants indicated that support from nurse educator; registered nurses including unit managers encourage accomplishment of clinical learning objectives. Some members of the multidisciplinary team namely doctors were mentioned to be assisting in realisation of their goals. Bruce et al (2011:174) describe psychomotor as involving behaviour that includes muscular action and also need neuro muscular co-ordination. It is further mentioned these includes:

- Imitation or copying of behaviour
- Manipulation by performing acts
- Precision by being able to carry out
- Articulation through co-ordinating activities
- Naturalisation meaning being able to do easily

Pupil nurses at their second year level needs support from nurse educators and other support systems including mentors and unit managers so as to reach a level of proficiency. According to an article on International Encyclopedia of Marriage and Family (2003:1) the central theme of symbolic interaction is that human life is lived in the symbolic sphere. It is further stated that the physical environment is also interpreted through symbolic interactions. Carter and Fuller (2015:1) also describe symbolic interactionism as a micro-level theoretical framework and perspective in sociology that focuses on how society is created and sustained through repeated interactions among individual.

In this study, the pupil enrolled nurses at their second year of study needs to interact with others in order to interpret how others pursue the roles that are expected within their second year of study, namely; administration of medication (oral, intramuscular, suppositories, inhalations); perform wound dressings; removal of wound drains; sutures; insert urinary catheters; observation of patients' neurological functions; as well as perform electrocardiograms. They can manage to enact such roles after carefully observing people around their environment; namely; mentors, preceptors, registered nurses and getting enough support. After their observation, they will reflect on what they have observed and they will decide to imitate that. The onus lies on whether what was observed was done in a good attitude, adequately and correctly enacted and the condition of the environment in which it was enacted. The pupil enrolled nurses at their second year level define clinical support by the way the nurse educators, registered nurses and mentors interact with them.

THEME 3: Clinical support not sustaining the caring component

The participant understood caring as a component and the application of its components such as respectful communication, feeling of acceptance, feelings of security and confidence. However they indicated some lack in the caring component and had to develop adoptive ways to thrive and be able to realize their goals.

- Provision of knowledge related to caring
- Communication attributes in clinical support
- Negative attitude versus positive attitude in clinical support
- Clinical support apparent not sustaining confidence

- Several adaptive mechanisms used by pupil nurses to learn and cope

The subthemes were as follows:

Subtheme 3.1: Provision of knowledge related to caring

The participants shed light into understanding the concept caring and its application. Support is the creation of a climate of open communication that is accepting and non-judgemental (Hamachek 1995:564). It is mentioned in role theory that individuals learn the roles through two processes being the one of interacting with groups and significant others and learning from role play, identifying, modelling, instruction, observation, trial and error, as well as role negotiation. In this study, the pupil enrolled nurses at their second year level are professionally socialised by following the second year curriculum of nursing study and has to fulfil both theoretical and practical component. This is where the theory that was learned in class has to be fully integrated into practice in the clinical learning environment. During this time, the pupil enrolled nurses at their second year of study have to learn values, interact and identify themselves with mentors. For socialisation to occur the pupil nurses at their second year of study has to observe how second year procedures such as wound care are performed, and they should be given chance to practice and be corrected. They have to be demonstrated how policies, procedures and records are utilised in providing quality patient care. They also need guidance to familiarise themselves in understanding and interpreting, for example, the doctors' prescription and all terminology related to their level of study.

Subtheme 3.2: Communication attributes in clinical support

The participants indicated that they mostly perceived disrespectful communication from most of the registered nurses. Demonstrating caring is one of the most powerful ways to build positive relationships with your students It is further stated that when your words and action communicate that you sincerely care for your students, they are more likely to want to perform well. Caring also fosters a preventive approach to discipline, as students who feel cared for are more likely to want to please you by complying with your wishes and policies (Kerman et al 1980 as cited by Boynton & Boynton 2005:2).

Subtheme 3.3: Negative attitude versus positive attitude in clinical support

The participants indicated that they experienced both negative and positive attitude from the some members of the nursing team including the unit manager, the nurse educator and some registered nurses. Blanchette (2015:8) refers to role strain as the state of distress that an individual experience when exposed to role stress and the individual is unable to fulfill role obligation. In this study the registered nurses will experience feelings of frustration and tension and may end up developing a negative attitude towards pupil nurses under study hence fail to provide clinical support due to role stress.

Rikhotso et al (2014:3), in his study, revealed that the disrespectful behaviour results in negative attitude by the registered nurses and students thus lessening their chance to be guided and supervised to be able to correlate theory into practice.

Subtheme 3.4: Clinical support offered not sustaining confidence

The participants reflected that there is a gap in terms of direct support during task execution to foster confidence. Croxon and Maginnis' (2009:240) study on evaluation of clinical teaching models for nursing practice also identified challenges that preceptors had on provision of support for the student due to staff shortages and demanding workloads. In that study, there was an introduction of cluster or group model support whereby one clinical facilitator was introduced to the group and this yielded better results in terms of support.

Subtheme 3.5: Several adaptive mechanisms used by pupil nurses to learn and cope

The participants expressed that they had to adapt and find ways of coping due to inadequate clinical support. Those adaptive coping skills included performing those clinical procedures on their own; they also had to come on their rest days for practice and assessments. They also ignored the comments by the nursing staff. The clinical learning environment provides the student an opportunity to apply theory into practice, thus learning to think critically, solve problems, make clinical decisions, and develop their affective, psychomotor and communication skills through interaction. They also

acquire professional values and they are socialised into the profession (UNISA, HSE 2602:37).

THEME 4: Challenges encountered

The participants encountered challenges due to lack of support from the unit managers, mentors, registered nurses leading to distress. The distress was associated to lack of supervision, being delegated tasks that are not at their level of training and lack of resources in terms of registered nurses and nurse educators.

The subthemes were as follows:

- Tales and personal distressing situations perceived related to clinical support
- Support versus lack of support from the unit manager, mentors and the nursing staff
- Support versus lack of support from nurse educators
- Resource utilised during clinical support
- Allocated patients' activities not related to level of training

Subtheme 4.1: Tales and personal distressing situations perceived related to clinical support

The participants reflected by means of telling tales with regards to their experience on clinical support which was distressing. The tales comprised feelings of distress during clinical placement related to them being exposed to a level lower than their level procedures and being left alone. This made them to feel unsafe as they were not sure that the skills practiced are done correctly and they could neither interpret the results.

Mtambo's (2009:28) study indicated that some of the clinical staff members perceive clinical support and guidance as not their task; hence in this study the registered nurses do fulfil their mentorship role in providing clinical support. This results from lack of clarification of the role expectation or disagreement. Role ambiguity occurs when the registered nurses role of mentorship is not clarified and expectations are not tabled (Du Toit & Le Roux 2014:93).

Subtheme 4.3: Support versus lack of support from nurse educators

The participants indicated that from they perceived support from some unit managers and registered nurses and some members of the nursing staff whilst some are not offering clinical support. According to Bruce et al (2011:257), the student learning objectives should be made known to the unit manager to facilitate their participation in realising them. The unit manager should be a role model and skills such as positive attitudes, communication, ethical behaviours and good interpersonal relationships should be learnt from her. The functional perspective of the role theory states that senior and older personnel from a profession has to orientate and induct new members of the profession *on what is expected from them, as well as show them how and when to do that.*

Subtheme 4.4: Support versus lack of support from nurse educators

The participants indicated that there is support from nurse educators in terms of demonstration, assessment, and sometimes practice of procedures but the challenge is that there are few given the number of students needing accompaniment. The nurse educators might be experiencing role overload. Blanchette (2015:27) describe role overload as when an individual experiences shortage of resources to possibly excessive demands. In this study the nurse educators and registered nurses might not be able to accommodate all the pupil nurses under study due to work overload caused by staff shortage.

According to SANC (R171 of April 1988, as amended) on guidelines pertaining to student accompaniment, it is stipulated that the nurse educator has to spend 30 minutes per fortnight accompanying a student.

Subtheme 4.4: Resources utilised during clinical support

The participants reflected that there are equipment to carry out tasks however the shortage is in nursing staff and nurse educators to provide support.

Moagi and Maritz (2013:358) confirmed that a learning environment that is fully equipped with resources but lacks support discourages students to look for experience thus reducing their learning and growth opportunities.

Subtheme 4.5: Allocated patients' activities not related to level of training

The participant expressed that they are not allocated according to their level of training and that contravenes SANC (R2175 of 1993, as amended) (SANC 1993b), states that there should be optimal delivery of care in a competent manner. The pupil enrolled at their second year of study has to master procedure set for the year in order to be considered safe practitioners.

THEME 5: Self-directedness of pupil nurses

The subthemes were as follows:

- Setting own clinical learning goals and objectives
- Taking responsibility to involve allocated mentors, tutors and ward staff members to teach
- Support in management of time: a key element during clinical learning
- Evaluation of outcomes

Subtheme 5.1: Setting own clinical learning goals and objectives

Most participants reported that they set goals and they present them to the unit managers who facilitate the realisation of those objectives. Literature reveals that there are still challenges contributing to students' non-realisation of their goals due to negative attitude from nursing staff (Moagi & Maritz 2013:359).

Subtheme 5.2: Taking responsibility to involve allocated mentors, tutors and ward staff members to teach

The participants do involve the mentors by showing them objectives but the reality expressed was that they do not get the opportunity to be observed by them due to

business of units. A study conducted by Chokoe (2013:49) indicated that mentoring calls for commitment from both mentor and mentee to achieve set goals. It was also mentioned that the results of the study indicated presence of commitment from both.

Subtheme 5.3: Support in management of time: a key element during clinical learning

The candidates indicated that their rest periods are taken away by the fact that they have to come for practice and evaluation.

Franklin (2013:34) study indicated that there should be development of unit model of supervision of students whereby students will be given attention in terms of on going support and education. In that regard pupil nurses will also have adequate time to rest.

Subtheme 5.4: Evaluation of outcomes

The participants verbalised that they only get to be evaluated by the nurse educator and before then they cannot measure their competency regarding different skills.

Supervision should support practice so that it can enable the students to maintain and improve the standards of care and the practitioner should be able to reflect on practice guided by a skilled supervisor.

5.4 RECOMMENDATIONS

Pupil enrolled nurses at their second year level at the hospital under study endured the challenges contributed by lack of clinical support. Therefore, it is mandatory upon nurse educators, managers and researchers to take note of the gaps identified and intervene so that the pupil nurses are fully supported to optimise their full potential in order for them to develop into proficient practitioners upon completion. Based on the findings of this study, the researcher propose the following recommendations for clinical learning environment, and the nursing education institution, as they work collaboratively, and for further research.

5.4.1 Recommendations for the nursing education

The researcher proposed the following recommendations for the nursing education: Pupil nurses are placed in the clinical learning environment in order to integrate theory and practice to become skilled, knowledgeable and proficient providers of high quality nursing care. According to SANC (1992:9), the main aim of nursing education is to develop the student capacity for critical, analytic, creative thinking and interpretation of data as well as making independent judgement. The students should be provided with the learning opportunities that ensure the broad spectrum of the curriculum. In order to achieve the above-mentioned goal as described by SANC, the following is recommended:

- There should be a close collaboration between the stakeholders at the NEI and the hospital in the form of communication and resources to improve and maximise their clinical placement. The NEI management to negotiate with the hospital management for more guided practical days to allow time for the nursing skill practice and assessment whereby students do not conflict with the ward routine.
- Constant evaluation of perceptions of nurse pupil nurses about the learning environment should be conducted in order to examine and clarify their values so as to improve and maximise their clinical placement (Chan 2002:74).
- Meetings and in-service training should be facilitated to focus the attention to registered nurses, preceptors, mentors and clinical facilitators on student learning needs as well as post reflective feedback.
- Nurse educators should be visible in clinical units.
- The nurse educators may reduce theory practice gap by incorporating methods such as simulations to align classroom teaching with the current realities of high occupancies, and shortage of staff.
- There should be incorporation of problem-based activities such as, reflective journals and learning portfolios for enhancement of critical thinking.
- The NEI should facilitate timeous recruitment and appointment of dedicated nurse educators to meet tutor-student ratio. The nurse educators should reach out directly where students are allocated, be sensitive to their needs, accompany

them, organise, structure and plan assessments, and keep accurate records of clinical teaching.

- The frequency of engagement of the preceptors in the role of facilitation and education needs further consideration.

According to NES (2011:2) clinical preceptors were recommended to ensure minimal level of clinical teaching and support students during their clinical practice for role taking. It is further stated that the NEI is responsible for developing a positive practice environment.

5.4.2 Recommendations for the nursing management

Bruce et al (2013:36) state that the main responsibility of the registered nurse in the unit is to ensure that the patient receives the highest quality care, and in instances whereby the students are unable to perform such tasks, they have a moral duty to ensure that they are being taught, supervised, and mentored.

- Registered nurses should be reminded of their role to teach students, when they are allocated in the units.
- The functional perspective part of the role theory states that senior personnel from a profession has to orientate and induct new members on the role expectations and also supervise them on performance and mastery of the new skills. The nursing manager of the clinical area should continuously commit to support student nurses as well as the nursing staff in performing their duties through:

    - Identifying the mentors.
    - All those expected to mentor, especially registered nurses, must receive in-service education.
    - Ensuring that mentors are available and placed on the same shift as the nurse pupil nurses for effective supervision to takes place.
    - Clarification of the roles of mentors in the unit.
    - Student mentorship should be enhanced in both clinical practice and NEI to develop student nurses professionally and personally.

- There should be adequate resources such as enrichment programmes for mentors so as to have improve mentoring.
- The unit registered nurse should be familiar with the objectives of
- The student nurse to utilise teachable moments to integrate theory into practice.
- Organising and providing adequate resources for nursing staff to execute their duties, by evaluating the unit occupancy levels and making sure that there is adequate and correct staff mixes to supervise and mentor students.
- Facilitating in service training and focus on issues such as communication patterns, respect, attitudes and interpersonal relationships to improve quality of relationships amongst registered nurses, mentors, and nurse pupil nurses.
- Establishment of student forums such as meetings to address their learning needs and challenges in the clinical learning environment and intervene accordingly to promote a conducive learning environment.

5.4.3 Recommendations for the nursing research

The nursing researcher recommends that future research be conducted and focused on:

- Conduct bigger studies that will involve all private hospital groups in Limpopo Province on nurse pupil nurses in order to explore their perceptions on support during clinical placement.
- Include other categories of nurse pupil nurses in the studies such as pupil nurses on bridging course leading to registration as a registered nurse. SANC (R683, 1989, as amended) to explore their perceptions on support during clinical placement.
- Conduct studies on roles of nurse educators, mentors, unit managers and registered nurses on clinical support for nurse pupil nurses.

5.5 LIMITATIONS OF THE STUDY

The study focused on one private hospital group and does not include perceptions of other pupil enrolled nurses at their second year level in other private hospitals groups in Limpopo Province, South Africa. Therefore, results of the study cannot be generalised to other hospitals within the private hospital groups.

5.6 DISSEMINATION OF THE RESULTS

This study results will be shared amongst the following categories of nurses namely: educators, managers, pupil nurses and registered nurses through presentations at research seminars and conferences. A completed thesis will be presented to the institutions where the student undertook her master's studies. Other copies will be presented to the Private Hospital Higher Education institution where the pupil enrolled nurses at their second year of study underwent clinical placement.

5.7 CONCLUSION

This study aimed at exploring and describing the perceptions of pupil nurses at their second year level of study towards clinical support during placement at one private hospital of the Limpopo Province, South Africa. Recommended supportive guidelines were formulated to support the pupil nurse second year during clinical placement.

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ANNEXURES

ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE: UNIVERSITY OF SOUTH AFRICA, HEALTH STUDIES HIGHER DEGREES COMMITTEE

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HSHDC/390/2015

Date: 11 February 2015 Student No: 3219-718-7

Project Title: Perceptions of pupil nurses at their second year level towards clinical support at the private hospital in the Limpopo Province, South Africa.

Researcher: Poto Magdeline

Degree: MA Nursing Science Code: MPCHS94

Supervisor: Dr TE Masango
Qualification: PhD
Joint Supervisor: -

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
for **CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**

L.H. Roets (Prof)

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B: REQUEST FOR PERMISSION TO CONDUCT STUDY AT PRIVATE HOSPITAL GROUP

04 March 2015
Mr Dewald de Lange
Mediclinic Corporate Office
Strand Road
Stellenbosch

UNISA university of south africa

REQUEST FOR PERMISSION LETTER TO CONDUCT RESEARCH

TITLE OF THE STUDY: **Perceptions of pupil nurses at their second year level on clinical support at the private hospital in the Limpopo province, South Africa**

I hereby request permission to conduct research among pupil nurses at your institution. I am currently studying towards my Master's Degree in Nursing Education at the University of South Africa. The aim of the study is to explore the support provided to the pupil nurses at their second year level during clinical placement, in order to better understand how best the clinical learning environment can be enhanced in order to develop them into proficient nurse practitioners. When their perceptions are understood, supportive guidelines to enhance a conducive clinical learning environment can be formulated and implemented to improve the situation and that will benefit all pupil nurses. The University of South Africa Higher Degrees Ethics Committee have approved the study.

This study involves no physical risks to pupil nurses. Their participation will include that we meet for a focus group interview, which will be voice recorded and may last up to an hour. The interview will take place in a comfortable private room. The researcher nor the participants will not address each other by names. All data obtained will be stored safe for confidentiality; and no names will appear on the research report or be published.

The participants will not be paid to participate in this study, but you may all benefit as a result of the supportive guidelines that will be recommended to enhance a conducive clinical learning environment. Nobody will be coerced into a study of which they do not want to be part of, they have a right to be excluded and will not be penalised in any way.

Yours sincerely,

Mrs M Poto (Student)
0843255073

Dr Masango (Supervisor)
0834113730

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

UNISA university of south africa

04 March 2015
Mr Dewald de Lange
Mediclinic Corporate Office
Strand Road
Stellenbosch

Dear Mr de Lange

REQUEST FOR PERMISSION LETTER TO CONDUCT RESEARCH

May I confirm that Mrs Poto is registered for a Masters Degree at the University of South Africa(Unisa). Her title of the study **is " Perceptions of pupil nurses at their second year level on clinical support at the private hospital in the Limpopo province, South Africa".** She is expected to conduct a research project in order to fulfil the requirements of the degree. She obtained ethical clearance from the Higher Degrees and Ethics Committee at Unisa .

Your assistance is highly appreciated.

Kind regards

Dr T.E.Masango (Supervisor)

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone +27 12 429 3111 Facsimile +27 12 429 4150
www.unisa.ac.za

ANNEXURE C: LETTER FROM THE PRIVATE HOSPITAL GROUP RESEARCH COMMITTEE TO THE PRIVATE HOSPITAL LIMPOPO PROVINCE

Coetzer, Rina

From: de Lange, Dewald <Dewald.deLange@Mediclinic.co.za>
Sent: 10 March 2015 07:08
To: Rapudi, Magdeline
Cc: Coustas, Estelle
Subject: Request for permission to conduct research

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Magdeline,

It give me great pleasure to inform you that the company has approved your research project, subject to the conditions set out below.

1. The company will be provided with a copy of the final research project/thesis once it has been submitted and graded.
2. Please liaise directly with the HR manager to set up the required interviews with staff members at Mediclinic Limpopo.

We wish you success with your study and please contact the undersigned should you require further assistance.

Kind regards

Dewald de Lange
Employee Relations Manager
MEDICLINIC SOUTHERN AFRICA

Mediclinic Corporate Office
Strand Road
Stellenbosch, 7600
T +27 21 809 6632
F +27 86 557 0906
C +27 82 728 2157

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ETHICS LINE 0800 005 316

www.mediclinic.co.za

12 March 2015

Att: **Magdeline Poto**
Head Nurse Educator
Limpopo Learning Centre
Mediclinic

Dear Ms Poto,

APPROVAL OF RESEARCH PROJECT

This document serves to provide you with formal permission to conduct a research project at Mediclinic Limpopo, subject to the conditions set out below.

1. The company will be provided with a copy of the final research project/thesis once it has been submitted and graded.
2. Please liaise directly with the HR manager to set up the required interviews with staff members at Mediclinic Limpopo.

We wish you success with your study and please contact the undersigned should you require further assistance.

Kind regards

Dewald de Lange
Employee Relations Manager
MEDICLINIC SOUTHERN AFRICA

Mediclinic Corporate Office
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C +27 82 728 2157

ANNEXURE D: LETTER OF INFORMATION TO PUPIL NURSES AT THEIR SECOND YEAR LEVEL

TITLE OF THE STUDY**:** Perceptions of pupil nurses at their second year level towards clinical support at the private hospital in the Limpopo province, South Africa

Dear Second year Pupil Nurse

I hereby request your participation in the above mentioned research. I am currently studying towards my Master's Degree in Nursing Education at the University of South Africa. The aim of the study is to explore the support provided to the pupil nurses at their second year level during clinical placement, in order to better understand how best the clinical learning environment can be enhanced in order to develop them into proficient nurse practitioners. When your perceptions are understood, supportive guidelines to enhance clinical support in the learning environment will be recommended to improve the situation and that will benefit all pupil nurses. The University of South Africa Higher Degrees Ethics Committee have approved the study.

This study involves no physical risks to you as pupil nurses. Your participation will include that we meet for data collection which will take place through written narratives, focus group interview which will be voice recorded and field notes. The voice recording may last up to an hour. The interview will take place in a comfortable private room. The researcher nor the participants will not address each other by names. All data obtained will be stored safe for confidentiality and will only be accessible to the researcher and no names will appear on the research report or be published.

You will not be disadvantaged in any way. You will not be paid to participate in this study, but you may all benefit as a result of the supportive guidelines that will be recommended to enhance support in the clinical learning environment. The research results will be announced to everyone after the study has been completed.

If any one of you have any questions concerning the study or participation or has a serious objection to be included in the study, you are free to discuss your concerns with me, I will not coerce you into a study of which you do not want to be part of, you have a right to be excluded and will not be penalised in any way.

I shall appreciate your willingness to be part of the study.

Yours sincerely,

(Mrs) M Poto

ANNEXURE E: INFORMED CONSENT

Research Title:

PERCEPTIONS OF PUPIL NURSES AT THEIR SECOND YEAR LEVEL TOWARDS CLINICAL SUPPORT AT THE PRIVATE HOSPITAL IN THE LIMPOPO PROVINCE, SOUTH AFRICA

The Researcher

I have discussed the risks, benefits and obligations involved in this research study with the participants and in my opinion, the participants understand this information

…… ……

Researcher **Date**

The Participant

I hereby give informed consent to voluntarily participate in the above research. I agree to participate through written narrative and focus group and also give permission for the voices recordings and field notes. I have read the information as provided on the leaflet and fully understand that my participation is voluntary and may withdraw or refuse to participate at any time.

....

Participant **Date**

ANNEXURE F: CODING REPORT

FOR: M Poto

DATE: 2015-09-20

STUDY: Perceptions of pupil nurses at their second year level towards clinical support at the private hospital in the Limpopo province, South Africa

BY: Prof MS Maputle

Method: Tesch's inductive, descriptive coding technique (in Creswell 2009:185-190) quoted in Botma, Greeff, Mulaudzi and Wright (2010:223) was used by following the steps below:

- The researcher got a sense of the whole by reading all the transcriptions and written field notes carefully which was followed by writing down some ideas as they come to mind. The researcher carefully and repeatedly read the transcripts of all the participants and understood them.
- The researcher rationalized the coding for the existence or frequency of concepts by listing all topics, covered by participants during the interview session. The researcher grouped similar topics, and those that did not have association were clustered separately.
- The researcher analysed transcriptions of the interview, and went through them asking "what is this about?" and "what is the underlying meaning?"
- The researcher abbreviated the topics as codes next to the appropriate segments of the text and differentiated them by coding the concepts from the collected data to include all meaningful instances of a specific code's data.
- The researcher developed themes and categories from coded or associated texts and reduce the total list of categories by grouping topics that relate to one another.
- The researcher analysed the results by coding certain segments of the texts attached to certain meaningful key and codes.
- The data belonging to each theme was assembled in one column and preliminary analysis was performed, which was followed by the meeting between the researcher

and co-coder to reach consensus on themes and sub-themes that each one has come up with independently.

Table 1: Themes and sub-themes reflecting perceptions of the pupil nurses at their second year level towards clinical support during clinical placement at the private hospital in the Limpopo province, South Africa

MAIN THEMES	SUBTHEMES
1 Cognitive domain: an integral part of theory practice integration	1.1 Knowledge related to the concept clinical support 1.2 Lack of cognitive support to enhance theory practice integration
2 Psychomotor domain enhance mastery of clinical skills	2.1 Reflection on clinical skills performance 2.2 Uncertainties experienced during performance of patients' care activities 2.3 Clinical support: a team effort 2.4 Psychomotor support leads to realisation of goals
3 Clinical support not sustaining the caring component	3.1 Provision of knowledge related to caring 3.2 Communication attributes in clinical support 3.3 Negative attitude versus positive attitude in clinical support 3.4 Clinical support apparently not sustaining confidence 3.5 Several adaptive mechanisms used by pupil nurses to learn and cope
4 Challenges encountered	4.1 Tales and personal distressing situations perceived related to clinical support 4.2 Support versus lack of support from the unit manager, mentors and the nursing staff 4.3 Support versus lack of support from nurse educators 4.4 Resource utilised during clinical support 4.5 Allocated patients' activities not related to level of training
5 Self-directedness of pupil nurses	5.1 Setting own clinical learning goals and objectives 5.2 Taking responsibility to involve allocated mentors, tutors and ward staff members to teach 5.3 Support in management of time: a key element during clinical learning 5.4 Evaluation of outcomes

Saturation of data was achieved related to the major themes and their sub-themes this is confirmed through identification of more verbatim quotes/excerpts from the transcription provided used in that analysis and each theme has five and more sub-themes.

Co-Coder: MS Maputle

ANNEXURE G: EDITING LETTER

EDITING AND PROOFREADING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

02 November 2015

TO WHOM IT MAY CONCERN

This letter serves to confirm that I have edited and proofread Mrs. M. Poto's dissertation entitled: **"PERCEPTIONS OF PUPIL NURSES AT THEIR SECOND YEAR LEVEL TOWARDS CLINICAL SUPPORT AT THE PRIVATE HOSPITAL IN THE LIMPOPO PROVINCE, SOUTH AFRICA."**

I found the work easy and enjoyable to read. Much of my editing basically dealt with obstructionist technical aspects of language which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors Group and also a language editor at Bureau for Market Research at the University of South Africa.

Thank you.

Hereunder are my particulars:

Jack Chokwe (Mr)

Bureau for Market Research (Unisa)

Contact numbers: 072 214 5489 / 012 429 3327

jmb@executivemail.co.za

Professional EDITORS Group

ANNEXURE H: FOCUS GROUP INTERVIEW GUIDE – CENTRAL QUESTION

What are your perspectives regarding clinical support during clinical placement at the private hospital?

TOPIC GUIDE LIST

1. What is your understanding of the concept clinical support?
2. How do you view clinical support with regards to; enhancing practice theory integration, acquiring and caring skill?
3. Please share your perceptions regarding clinical support provided by the nurse educator, registered nurses and mentors.
4. What challenges did you encounter in the clinical learning environment that could have been prevented by good clinical support?
5. How do think the clinical support can be improved?

ANNEXURE I: EXAMPLE: THEMES AND SUB-THEMES

ANNEXURE I: EXAMPLE: THEMES AND SUB-THEMES

Date: 2015-09-20

Researcher = R

Participant = Resp

Population: pupil nurses at their second year level first intake
Number of participant: 8

Coders	Transcriptions	Themes
	R: Good morning. Let me welcome you all and thank you for the session that we will be undertaking. As it is already indicated and you have read from the information leaflet. I am intending to explore the perception of the second year level on clinical support during clinical placement at the private hospital? So we are going to go through the topic guide list and the topic guide list will enable us to explore all the questions that we need to explore within the study. First kindly tell us what your understanding of the concept clinical support? RESP A: I think it is support provided an environment where student are given the opportunity to learn from practical experience and gain experience from those who had already had that kind of experience. They are giving you what they had learn and the lessons they had learnt, how to deal with things, on a one on one, as well as the broader platform that is more practical approach that you get to apply the theory you have learnt, that is where you show your understanding for what you had learnt. R: I understand RESP A very well you said it's an	

environment that will enable you to learn from other people the way they enact their role.

RESP A: Yes , as well as **practical approach on what you had learnt from theoretical component**

Comment [m1]: 1.1

R: What are others saying views on clinical support.

RESP G: My understanding of clinical support is that it's about having someone in the clinical environment who's going to be available for you at all the **time to give support and guidance on every aspect that you may need in case procedures and should they be performed and stuff like that.**

Comment [m2]: 1.1

R: RESP G If I may clarify you are saying having someone with you, who do you mean buy those someone with you?

RESP G**: That someone may be the allocated mentor or the nurse educator** always available for you all the time.

Comment [m3]: 4.2, 4.3

R: Okay others, other participants.

RESP C: I think clinical support is whereby the **clinical team referring to the nurses, doctors, caregivers work together as a team so as a certain goal** can be reached for example: maybe patient comfort, reassurance or helping a member of the team to meet certain demands within the environment , that's what I think.

Comment [m4]: 2.3

R: Thank you very much RESP C. Any other addition?

RESP B: As RESP A,C & G have already discussed it's where **health care workers have** been exposed to some encounters and they come together and keep learning on every day basis and they **give support to specific students, their objectives including goals** and the achievements.

1. R: So if we had explore it fully up to your satisfaction, the will move over to the second topic guide list, which is how do you view clinical support support with regards to; enhancing practice theory integration, acquiring and caring skill?

RESP A: I think clinical support in general as whole can be described as productive and useful however it does differs from person to person , not everybody is born to teach, not everybody has the same patience as the next person, but I have observed that a **unit manager who are more positive to** training and development encourages students in the unit , they like trying **pass on the knowledge** and I don't want to say they influence but the staff that works with that particular unit manager generally is more supportive and more helpful towards the student learning environment. They tend to help **you achieve your goals** a little better and they are **generally more supportive.** You may find that there is a procedure that you specifically needs to be done or they see a procedure you have not been exposed to , then they will call you and say that I know you are in second year , uhm you have never witness as ECG things like that or may you come and help or witness .

R: If I understand RESP A very well, she is becoming broad I need you to be specific , you said in general it is there , so

Comment [m5]: 2.3

Comment [m6]: 2.4

Comment [m7]: 4.2

Comment [m8]: 1.2

Comment [m9]: 2.4

Comment [m10]: 3.1

	when say it is there or partially can you clarify because we have got different areas like theory practice integration, skills and care acquisition. RESP A: Some unit managers are more encouraging to you, its not necessary that you need to baby them or follow up all the time, they just take an interest that their staff see that, example , so that when they see that you are benefiting from the unit , are you achieving you goals , uhmm , am not saying that they are taking their responsibility away from the leaner. From are person who is experienced there you approach not only the unit manager and say this are may objectives this is what I want to reach but the registered nurse and the mentor with the objectives and say this is what to accomplish they are generally more helpful to you. If you have gone to them personally with the right attitude and the right etiquette you would win. RESP A: Yes but not always {laughter } that's why elaborated so much R: Okay, any other views /perceptions? RESP G: From what I have experienced in the unit, and from what RESP A said, if the is an opportunity let me say ECG, if they got an ECG in the ward and they know its in your scope they are going to call you out and say there is an ECG there, but the problem that is there is that no one is going to accompany you to sort of help you with that procedure so that you can do that procedure adequately or in the right way. They just point you that there is an ECG there and after that no one is interested in seeing you results even if you go the person who send you to do that ECG**, your mentor and**	

	say here are the results I obtained, they will just say you should keep them there the Doctor will see them because am not there one who's looking for those results is the doctor. From there I can say there is support provided but the **support is very minimal and there is no one to go after you and point at that thing that you should do.** You know what you should do they are not going to come back and say how was it or even if you go after them and say this is what I have encountered they don't have that time because everyone is busy , you are on your own. R: So RESP G If I gather what you have said , you got an exposure to your learning needs for example you mentioned ECG but you don't get enough support in pursuing the identified need , in terms of making sure that you understand what you doing. RESP G: That is what I meant. R: You mentioned that they do not have time but got time for their own things. RESP G: By their own things in other words everyone is allocated to do certain things. Like the sister is allocated for medication and for mentoring the student even though that **mentoring is very minimal** as I mentioned again their own things I just meant things they are allocated to do when they work. R: What kind of things? RESP G : Medication ,rounds as I already said	

Comment [m11]: 4.2

Comment [m12]: 1.2

Comment [m13]: 4.2

	R: You mentioned part of mentoring as part of the allocation but is not sufficient, what do you mean by that . RESP A: They don't see it as a priority RESP B: Simply I can say you learn the hard way or you learn as an experience of exposure this support to see that you did an ECG right and if you see a chance to be **with the doctor to explain the ECG results,** you can be sure or learn from the one that you did previously that I did it the right way or the wrong thing or where's you could have known if you did the right thing immediately when you went to your mentor or registered nurse. R: Thank you for the inputs .other people how did you view clinical support in terms of enhancing theory practice integration, acquiring practical and caring skill. RESP D: I think the only **support that we get during clinical placement is from our tutors. I** know like the procedure might be available and we like to meet our objective might be there but there is no one to be with us but then if we call our tutors they are there for us when they are available, they always support us unless they don't have time or you tell them at short notice if the ECG is needed immediately, but otherwise in the hospital the support is very minimal like RESP G just mentioned. RESP A:I want to add onto what RESP G&E said, I agree with RESP D, about **the tutors being available** also been kind like what participant G said, they point you in the direction where procedures are **, but there is no follow up in your skill or skills are not developed ,** where we are	Comment [m14]: 1.2 & 2.3 Comment [m15]: 4.3 Comment [m16]: 4.3 Comment [m17]: 2.1

told by our tutors that we are to practice in the in the unit before an evaluation , which is what we do but like RESP G said **we don't know if we are doing the right way** due to lake of support or business , also not just the business that our mentors that you may find you are allocated a site a certain unit number ,they will tell you just go and get an ECG done ,the is an ECG available on the other side of where there is another bed , and you have been allocated to do a certain amount of work on your side and you actually don't have enough time on your side necessary practice what being made available to you if that makes sense , sometime the opportunity is there but you can't take advantage of it.

Comment [m18]: 2.2 & 2.4

RESP A: So because you have to fulfil the allocated task first

R: What compose of this allocated task are they not part of expected objectives during second year?

RESP C: When an in the unit **am allocated as an auxiliary nurse meaning I do the vital signs, the blood glucose.** patient come forward of which that you must all do to ensure that the patient are comfortable but then am studying towards being to be an enrolled nurse , when do I get time to practice to bean enrolled nurse if am allocated as the ENA { Auxiliary nurse}

Comment [m19]: 4.5

RESP A: I agree strongly

R: So how does this allocation of your previous year, that is procedures as an auxiliary nurse how does it affect your second year of study.

RESP C : I **think we never get time to practice our procedure and to meet our objective** **like** even sometimes even **if I get a chance to do something I don't think it will be enough like maybe if I was allocated to work with the enrolled nurse I would learn a lot but if I am the ENA I don't get much time to do all may planned objective** **like** sometimes I end up not meeting my objectives

Comment [m20]: 1.2 & 2.4

Comment [m21]: 4.5

R: Okay that is clear.

RESP A: I don't know you are saying as RESP A was it more of shadowing sort of mentorship that you work closely with either the RN or the EN then you get that exposure where you ask for the comparison of what it was like in our previous your where it's also to do with the scope was you can't practise below what our scope was last year it was the bottom and we were the base so if we were given the opportunity we could work up but now we can either work up or down and **also** **I think due just to a problem of not being enough nurse in general then the understaffing** takes away the learning opportunity

Comment [m22]: 4.4

R: How does this all makes you feel?

RESP A: **Frustrated.**

Comment [m23]: 4.1

R: Do you experience it the same or do others may get advantages of being allocated differently.

RESP B: Sometimes it is important to take it as a challenge to say I can try it by all means to **push at least two or three objective a day** but is not always as easy or possible because of the busyness of the ward, or shortage of staff or

Comment [m24]: 2.4

understaffing as per allocation method. As it can be but otherwise you just tell yourself I can try and spending the whole week only having achieve two or three objective by that I mean you are going to be exposed to them two or three times which is not amble of time to practice, can I say it was just a practice cause what you have been exposed to its once.

R: Ok I gather what you are saying, what I want to establish is that how does all that makes you feel?

RESP A: It's frustrating you been **hindered from achieving what you feel you are there for.**

Comment [m25]: 5.1

R: And others?

RESP G: I think like RESP A has said its very frustrating because you know why you are in the wards but you don't have ample time to perform what you are there for because of I think the most contributing factors are that in the wards we **are considered as more of the work force** than student if we were to be considered as student then we are going to have ample time to perform and achieve our objective ,because we are the work force and if we are going to take time to be student then the work is not going to get done at the end of the day **, the work of the auxiliary** because we are considered as auxiliary

Comment [m26]: 4.4

Comment [m27]: 4.4

RESP A: Strongly agree

R: Is there anything that you want to explore with regard to your experience at the second year level you might be thinking of now before we move on?

	RESP A: No I think we are fine. R: Thank you very much we are going to move over to the third question which is on the nurse educator, please share your perceptions on support that you get from your nurse educator or tutors and accompaniment and support from your nurse educator. RESP A: The biggest challenge I find with support and accompaniment, has been mostly uhmm I don't know what the word staffing. if I can say **we lost a tutor last year** and we in the process of training new ones I don't wanna say lost it sound like……. R: What do you mean by lost a tutor? RESP A: One of our nurse educator resigned ,**our tutors are trying to split themselves thinly amongst us** so many of us and with the new ones in training we cant really utilize them yet , its improving already but the time allocation for our tutor to us is limited R: Okay point taken RESP G: I think to add what RESP A is saying is saying there is support, but their support is very minimal and we are a large number, so the support is not, sort of not enough to cover the whole of us. In case you want to uhm perform a procedure with our educators considering our large numbers, you have to book weeks in advance to be evaluated and then there are at some cases, you just across some certain procedure and you want to call the educator immediately for	Comment [m28]: 4.4 Comment [m29]: 4.4

evaluation, and **unfortunately the educator is almost always overbooked.**

Comment [m30]: 4.4

RESP A: Like sutures and clips.

RESP A: They are rare procedures, it's **really frustrating they go pass without supervision.**

Comment [m31]: 4.1

R: Can other people, participants experience it, the role of the nurse educator, when accompaniment is concerned.

R: It seems we only had three inputs so far.

RESP B: I will **give credit to the tutor for their effort** is just that there are challenges that they meet, **outweighs the results we should see on the learners like the other RESP has said time and the availability.**

Comment [m32]: 4.4

Comment [m33]: 4.4

RESP F: The only problem or challenge that I have crossed is that when you find a procedures and you want to do it immediately you should have booked but rather than that they are very supportive they **encourage us to do procedures.**

Comment [m34]: 3..3

R: Ok other Resp experience Resp E:

RESP E: The **educators are supportive and they motivate** us to do our work in time, they always encourage us to do our procedures like **we don't have to wait for the last minutes** and we have to book in time like weeks before you can do them and get enough chance to practice the procedures but even though sometimes we get procedures we want to do them now, they are **busy with classes and**

Comment [m35]: 3.3

Comment [m36]: 2.4

	they are not available so that is the only challenge I get. R: So what I'm gathering from the support on the clinical accompaniment from the nurse educators, you may add if I may have left something's. What I'm gathering is the ratio is not that adequate because of the limited number of personnel also the exposure to new ones and also it was mentioned that not available on spot procedures and they can't cover the large number and other big problems is you have to book in advance and then you miss out in rare procedures but in generally on overally they are supporting and encouraging you, and because of their commitment in classes then they are unable to offer that. R: Yes, that is what we meant RESP D: And even if we come across like **emotional stress,** emotional like very bad time like personal vibes like they really support us emotional and privately and confidentially and even if we don't perform in the classroom up to the required standards they **try to talk to us and try to understand our problems** and how we can resolve the issues, if we are facing an issues. RESP A: Just wanted to add support is good but accompaniment is challenged from the reasons you mentioned. It's not a personal thing at all it's just **logistical problems.** R: Thank you if its sum up all what it is you have or perceived in terms of the nurse educator and then the same question goes no for the registered nurse and the mentors with regard to clinical support provided.	Comment [m37]: 4.4 Comment [m38]: 3.1 & 3.2 Comment [m39]: 3.1 & 3.2 Comment [m40]: 4.4

RESP B: So the support from the registered nurse and the **mentors in the unit is poor, minimal** almost impossible to say insignificant not because they want to but because of the responsibility that they have in the wards, they have a lot to do and also because of the challenges of the understaffing you find literally on a forty bedded ward they are two registered nurses or three registered nurse they all have to look after all those 40 patients, they all have to supervise and support their staff nurse, their auxiliary nurse and their care workers also the students, so because of the allocation time frame, the support we cannot spot it say.

Comment [m41]: 4.2

RESP A: Also using our portfolio of evidence as an example it's only a registered nurse who can sign it for you and now the correct way of that being sign is that the **registered nurse is supposed to be with you watching you that procedure** in order for the to sign the reality of that is often you can ask the staff nurse or a previous student to watch you and then report to the registered nurse that observed her and she's done the right thing for example. But then you do get the occasion where the registered nurse is available to you but then as soon as she come to you the phone rings or the doctor comes it's the same as what RESP B was saying just it's too much to them almost so if we can maybe introduce as an example the EN are also able to maybe be accompaniment for us for that portfolio but let's rather say strictly those who have the same training or understanding that the tutors are enforcing us, so maybe specifically EN who were trained the same way we were .

Comment [m42]: 1.2, 2.4, 4.2 , 5.2

R: Other resp how did you experience nurse with the role of mentors and registered nurses and if one can clarify the

	mentors and registered nurses and how is that been done elaborate more on that. RESP G: **I think fellow resp A and B have said a mouthful** with regards to support that we are getting from our registered nurses and our mentors who are very minimal if not thoroughly and on the mentors and registered nurse we do not have a person who can say this is your mentor. The allocation you may find that on daily basis as you are working you are allocated a new mentor, because the mentor is always the registered nurse and the registered nurse is always having too much on her plate to have time for you . R: Ok and how is this mentoring being done if you can take me through that. Mentor, mentor allocation and how's the mentoring how do you perceive that? RESP G: I can say there is no mentorship. I think it's only one paper **that they have written that this one is your mentor** but you will never find part where your mentor is there for you because they are always busy. RESP B:To add what resp G is saying, I was allocated in one ward where **the matron actively said I'm allocating these mentors to you because your off duties and hers are the same** but the rest of them they just say these is your mentor but tomorrow your coming to work and she's not there. That day are off she's at work. R: So your experience was only at one unit where you really observed that? RESP B**: Yes, even though she was busy.**	Comment [m43]: 4.2 Comment [m44]: 4.2 Comment [m45]: 4.2 Comment [m46]: 4.1 & 4.2

	R: How often were you experiencing support RESP B: She was available for the days not available for me. RESP A: **The experience is the same thing I think it's the** same unit but I did experience in another unit where I said to the unit manager listen I need to do this and this and she also did the same thing she looked at the off duties and said well for this specific. I'm allowed to be specific? RESP A: Ok we are not allowed in the labours room in our scope but we have to do a final massage not that only happen in the labour room or after caesarean if bleeding occurs, so when I approached my unit manager I said listen I need to do this and this and she said no of course. This is the sister I want you to speak to your together on Sunday and it's a quiet day and she even spoke to sister and said this students has approached me with this objective they are not really allowed in the labour room for personal reason it's a very emotional time for those patients and I was given that opportunity. R: So your experience is not at all units but some. But some unit if opportunity do allow, do give you the opportunity to have a mentor. what Resp B said although it's on the off duties on the same shift sometimes you don't get individualised mentoring and support is that correct? RESP A: Yes R: Ok any other experiences regarding your mentors and your registered nurses RESP C?	

Comment [m47]: 4.2

RESP C: **With regards to the mentors for me it's not often** that I get to have a mentor in the clinical environment so I cannot say anything about the mentors but they sometimes allocate the registered nurse that you be working with to be your mentor for the day but I don't think she can be my mentor for the day because she cannot see progress. I think a mentor needs to be someone whose going to be with you on a daily basis because if someone just be a mentor for a day tomorrow when you need to clarify something the person is not there then we cannot call it mentorship.

RESP A: It needs consistency

R: Consistency, what do you mean by that.

RESP D: **In one ward I have experienced that my mentor** was on the same shift as me. Where we were allocated. It was ever put in the kitchen with student's names and their mentors. So I would be on the same shift as my mentor and on the same side every time. So I was allocated with the mentor on the same side and that person is the person who's going to write my report at the end of the month but mentoring and everything zero.

R: What do you mean by mentoring zero?

RESP D: **When I need support in doing some of the** procedures her being there with me she couldn't because she had other duties to do.

RESP D: **And she is going to write my report at the end of** the month and they are not nice things.

Comment [m48]: 4.2 & 4.4

Comment [m49]: 4.2

Comment [m50]: 1.2, 2.1, 2.4 & 4.2

Comment [m51]: 4.1

RESP G: I think what we are all saying that we are not getting **the mentorship** but is not because the registered nurse doesn't want to. The main contributing factor is that the registered nurse doesn't have time for this mentoring thing.

R: Ok

RESP B: **Even if they are allocated for mentoring they don't** have time.

RESP G: Yes

RESP B: In other ward they are not allocated to mentor you, they are just in paper they are your mentor but practically you are on the other side and they are on the other side. You are on the other shift they are in the other shift.

R: So in all or in overall how does this make you feel or how does it affect your second year level or your attainments of your second year level goals?

RESP A: **I think it's a as RESP B has said a bit overwhelming,** because your are trying to learn trying to do the right things. This year we are taking a lot more responsibilities, we doing a bit more responsibilities, we doing a bit more dangerous procedures or they could risk your patients more invasively, more invisibly, so you feel a little bit intimidated to go forward with for an example, giving an injection because the reality is being instilled the dangers of giving an injection from allergies to physical injuries to your patient. So you are holding back in getting that done

Comment [m52]: 4.2 & 4.4

Comment [m53]: 4.4

Comment [m54]: 1.2, 2.1, 2.4, 3.5 3.2, 3.3 & 4.4

because your are scared but you can't go forward because there is no one to be over your shoulder first couple of times you tried it. I hope it makes sense.

RESP A: **"Giggling" like we might not reach that goal.**

RESP D**: I think we have learned to be independent uhmm**, we have never ever been dependent on them, really because they have never been there for us at all the mentors.

RESP A**: I disagree with participant D in that because** independence is always great and we have achieved that but independence based on what independences is based on thinking you can do it or where you achieved that somebody saying you did a really good job next time rather hold a needle like this, or just little things, you more confident in what you have achieved cause someone with experience has told you, you have done it correctly, as supposed to as gaining independence cause you have never shown anything better.

RESP B: What I can say is you are going to say I am confident and I am competent in doing this, but you are going **to day I have learnt this, and I have experienced this, and I can ascertain that this might be wrong** and this might be right, this might work and this might not work, but you cannot say I am competent in doing an ECG, e.g. I know how to plug an ECG and I know how to put up leads, or operate this.

RESP A: Yes I only feel competent in what I am doing once the **tutors evaluated me** and giving me those pointers, but I don't want to feel like I only, I **don't want that confidence**

Comment [m55]: 2.4 & 5.4

Comment [m56]: 3.5

Comment [m57]: 3.2 & 5.2

Comment [m58]: 1.2

Comment [m59]: 4.3.

only after being evaluated because up until then my evaluation is completely nerve wreck because I don't know that I am competent until she has evaluated me, with her evaluation she must just be a tick yes, confirm that you are doing this right.. I don't want her to be the beginning and the end of my competency.

R: So we going to move on to the third question, which saying " how do you as a learner now regard yourselves as a leaner and you know what a leaner is ? How do you prepare before you get to the clinical placement or how do you prepare when you get to the clinical placement from your side?

RESP B: **Because first you need to plan your goals and** objectives you put them down and set some time to say I can achieve this by the end of this placement in this ward, that is how you prepare and then on your free time you call your tutors to practice of call your mentors to practice or your tutors to evaluate you.

R: What do you mean by free time, you mentioned that free time?

RESP B: **Free time I mean in the ward they can say there is** tea from 10h00 to 10h30 you can take that time if you ate in the morning from my personal view if I ate in the morning from home I usually take that time to practice.

R: So meaning that you are utilising your time that you should be having your rest and your tea?

RESP B: Or you can come on your off days then you can

Comment [m60]: 3.4

Comment [m61]: 5.1 & 5.2

Comment [m62]: 5.3

	practice or get **evaluated.** R: On you're off days? R: Okay, how do others prepare when coming into clinical units for practice, how do you normally prepare? RESP A: **I agree a lot with what RESP B has said although I** just want to add onto his topic of free time , what I have just discovered with planning your objectives, you approach you unit manager for those specific objectives obviously your priority we have a very long certain objectives. So if you prioritise according to the unit could present what is available to you in your objectives prioritise those objectives and just address the unit manager and try discussing with her. The staff as much as possible you can be supported and the you won't necessary have to use you free time , although it usually happen like that as RESP G said on the previous question , because we are considered such as being among the workforce , uhm is easier for us to do this things in our off time it's not really insubordinate when someone say please do this and you can say no, am here on my time for my procedure or whatsoever you may be doing R: what you are saying that you find it more convenient to practice and be evaluated where you are not on duty RESP A; I think is only because you can't be disturbed. R: Disturbed by? Allocation or your routine? RESP A: Yes	Comment [m63]: 5.3 Comment [m64]: 5.1, 5.2, 4.1 & 3.6

R: That you are supposed to finish
R: How do others prepare for clinical placement is the same? What do you do normally when you go there or before you get there? RESP E you are a bit quiet.

RESP E: I **think I got time to do my objectives like as RESP** A said obvious during the working we are busy with the routine I agree with RESP A.

Comment [m65]: 5.1

R: RESP D you were still saying?

RESP D: The preparation start at the learning centre where all procedure are demonstrated to us by our tutor and how we should able to document in all the hospital documents like on our level , so then we get enough time to practice and be evacuated until we are competent in clinical placement so when we get there is where we plan for the objective for the specific wards so that we can practice what we were taught in the learning centre and implement it in the hospital and then in planning my objective plan them according to the ward ,that I am going to and that help me to meet my objectives at the end of the stay in the ward.

Comment [m66]: 5.1

R: Any other perception a planning for the clinical placement does it sum up how you normally plan you journey to the clinical placement and how you thrive in there?

RESP A: **I just what to add how important is your evaluation,** you need to try and be observed by your mentor and tutors just to check on your skill for what were we discussing earlier and we having a challenge with, its important to improve your skills by being observed and

Comment [m67]: 5.4 & 5.2

	mentored as assessed as preparations of evaluations and self-development . R: What we did not explore there is you have told us in tell of getting competent in terms of routine and how do you normally adapt to difficult situation, how do you normally like concertize yourself that , I have to survive in the clinical ward . How do you prepare to adapt to difficult situation. RESP G: **This year in our second year, I think it's much more** easier for us to survive cause we know what to the expect from certain individuals in certain wards , unlike in our first year it was very hard to survive , because everything was new to you ,and when this person comes to you and be mean I wouldn't like to say mean, come with their own normal way of living I am going to take it as this person is rude and that I was doing in my first year, so in my second year I will know that this one is going to come and be rude, I am okay with that, and that is what I am already expecting from that person. R: Meaning that you have development coping mechanism? Your previous experience has developed you to have more coping mechanism. RESP G: Yes you know what to **expect from them.** R: Meaning that the environment, the personnel that are there have already adapted to even challenging situation? RESP G: Yes RESP A: **Yes they have thickened our skins,**	Comment [m68]: 5.5 Comment [m69]: 5.5 Comment [m70]: 5.5

RESP B: **We learn according to exposure or experience**

R: Okay

R: How do you think this clinical support can be enhanced or improved looking at all the points we have highlighted and all what we have discussed and what you came about.

RESP A: **Just what RESP G said about student, if there was** a bit more of a definitive line saying you are here to be a student, you are going to learn and you are going to practice versus you are here to earn money, you are here to work uhm to work yah,

R: Other input.

RESP G: **We have been talking about lack of support, lack** of support, so I think I know their budget constrains and all those combined, but I think if they could be nurse educators, who are fully based in the clinical field, then we will always have somebody by our side, even that competency we are going to be more confidant, when we have got our nurse educators who take us by our side all the time, and say this is wrong, this is the right way.

RESP C: **As a second year nurse student I would advice the** mentors to be allocated in the clinical environment, and mentors needs to be people who are hardworking and people who are always willing to teach people uhmm and clinical team, should be aware of our learning requirements, so that they can be able to assist and be supportive, and also the units needs to be well staffed so that we can get time to

Comment [m71]: 5.5

Comment [m72]: 4.4

Comment [m73]: 4.4

Comment [m74]: 4.2

do our objectives, thank you.

R: Thank you RESP C

RESP A: Also that our mentors be leading by example not shouting and **them doing the opposite.**

R: To be a role **models**

RESP A: **"Yes"**

RESP B: Mentors has to be competent teach us the correct things. You find that your teachers showed you how to do a thing, the mentors there is doing it differently, and wrong.

RESPG: Just to support RESP B,I think it is amazing how things that we were taught at the school at the learning centre differs so much to the things that are actually happening in the wards, because they are very different.

RESP A: **Also supporting what my previous colleagues have** said it you pick up bad habits where you are mostly exposed, and unfortunately our habitual routine comes from the clinical learning environment, not necessarily we get a very small ratio of student –tutor interaction compared to our clinical exposure.

R: Okay how else can it be enhanced?

RESP C: **I also think that the mentor needs to be the people** who are competent with our like our objectives and procedures. Sometimes you find that the person who is allocated to be your mentor doesn't even know how to do

Comment [m75]: 3.1

Comment [m76]: 3.2

Comment [m77]: 3.2

Comment [m78]: 2.1

Comment [m79]: 4.4

Comment [m80]: 1.2 & 2.1

	that procedure that you need him or her to assist with that. You may find that person doesn't not know how to test urine. RESP C: Exactly RESP B: The basic thing can lead to infection, and can lead to our patients getting worse with that RESP A: Incorrect reading during urine analysis RESP B: They are not careful and they need to know what they do with **the** procedures it is very important. RESP A: Medico legal risks RESP C: **And then once again you can be honest if you dont** not know how to do a thing and refer to someone who know and is competent and in future you can be a good mentor to someone, thanks. R: Did we explore all the recommendations for clinical support RESP B: Yes, the unit must be aware of the responsibilities, like **second year practical day is on the 11th, because staff** nurses running the wards it was like chaos, with only one registered nurse and unit manager going up and down. RESP A: And also it goes a long way in any environment, we have our hierarchy and respect and as much as we need **to be respectful of** our R/N and E/N as students we automatically assumed that	Comment [m81]: 1.2 & 2.1 Comment [m82]: 5.2, 5.4 Comment [m83]: 4.2 Comment [m84]: 3.1, 3.2 & 3.3

	will be their “skivvies” we can run, we can just hop skip, and jump to their demands because we are the tight lip students, whereas as ENA or EN who has more experience than me and age wise is older than me, an the hierarchy I am technically above that person then they will still send you around to do things that aren’t your job, and not to say you need to be disrespectful of the elders but just that respect is earned. R: You need to be respected as an individual even if you are a student. RESP A: Yeah, and your rank at the workplace unfortunately takes presence over, in the workplace we are equal, take preference over age and staff. R: Is there any other point that you want to add with all the focus group questions that we have attempted, or maybe come to you mind when we were busy starting from the first question to the last one. R: The first one was on the concept clinical support and two was on your skills, theory practice integration, practical and caring skills, the third one was nurse educators, mentors and professional nurses, and the fourth one was your encounters, fifth one was how do you prepare for clinical support and how it can be improved. R: Anything that you want to add. All RESP A,B,C,D,E,F,G,H: No thank you R: I would like to thank you all respondents’ for having	

	participated in the data collection and then we will give you feedback on the outcomes of the study and recommendations. I am closing the session. Thank you very much. All RESP A, B,C,D,E,F,G,H: Thank you.	