MENTORING NEEDS OF CLINICAL FACILITATORS

by

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submitted in accordance with the requirements

for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

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SEPTEMBER 2016

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DECLARATION

I declare that **MENTORING NEEDS OF CLINICAL FACILITATORS** 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 institution.

13 September 2016

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MENTORING NEEDS OF CLINICAL FACILITATORS

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ABSTRACT

Clinical facilitators facilitate the clinical training of students in the hospitals at which students are placed for the practical component of their studies. Clinical facilitators' success depends on their ability to facilitate students effectively. Students who have been effectively facilitated have the potential to become competent bedside nurses to their patients. This is sure to lead to better patient outcomes and will therefore have a direct impact on the quality of nursing care. The clinical facilitators who are appointed to facilitate students in the clinical learning environment are, however, not necessarily empowered and skilled to teach their students effectively. If their own mentoring needs are addressed, clinical facilitators may be assisted to become more effective in their transition from clinician to clinical facilitator.

A qualitative study was conducted with the purpose to explore and describe the mentoring needs of clinical facilitators with a view to proposing a mentoring programme for effective clinical facilitation. Data were collected by means of focus groups with clinical facilitators working in a private hospital group.

The findings of this study confirmed the need for mentoring. Mentoring of clinical facilitators contributes to their skills and understanding of clinical facilitation. As an outcome of the study, an outline of a mentoring programme was drawn up which could be used in the orientation and mentoring of novice clinical facilitators.

KEY CONCEPTS

Clinical facilitation; mentee; mentor; mentoring; student.

ACKNOWLEDGEMENTS

I am ever grateful to the Lord who has given me the strength to run this race. Lord, it is in you that I am able to overcome my weakness and in you that I am able to celebrate my success. You went before me and made my path straight. To you Lord, all the glory and honour.

I would like to thank the following people for their support and encouragement:

- Prof Gisela van Rensburg, my supervisor – You were my strength in times when I felt weak. Your words “You make me proud” meant more to me than you will ever know. You have been an inspiration to me.
- Paul, my husband – How can I ever thank you enough for always believing in me, for listening to me patiently while I discussed my journey with you; for sharing my excitement whenever I celebrated a milestone during the course of my journey. You are a rock in my life and you supported me throughout this journey.
- Cheré and Luan, my children – You were so understanding when Mommy needed to work on her studies. You are special kids; you are one in a million. “Julle is meer as waarvoor ek ooit kon hoop, droom of bid.”
- Willie and Hester, my parents – You raised me never to give up and this helped me in my journey. You never stopped supporting and believing in me. Your cellphone messages, meals, phone calls and prayers carried me when I needed them so badly. How can I ever thank you enough?
- Corné, my sister – Your prayers kept my arms strong. You are a light in my life. Thank you for every word of support, every bag filled with goodies and sweets as small tokens of encouragement. I will always love you.
- My family, friends and colleagues, who encouraged and supported me.
- Prof Dirk van der Wal – for co-coding my work.
- Marius and Engela Pretorius – for the language editing of my work.
- Mrs Rina Coetzer – for the technical editing of my work.

To you all, my sincere thanks. May the good Lord bless you and keep you.

Dedication

I dedicate this dissertation to the following special people:

Paul, Cheré, Luan, Willie and Hester.

I love and appreciate you more than you will ever know.

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Clinical facilitators are responsible for facilitating the clinical training of students in the hospitals in which these students are placed for the practical component of their training. The development of student nurses as clinical practitioners is facilitated by means of clinical accompaniment. Though clinical facilitators do not always have experience of nursing education, they are promoted from clinical practitioners/nurses to clinical facilitators. The researcher is aware that, in South Africa, clinical facilitation does not follow any set pattern. In the private hospital group in which this study was conducted, clinical facilitators are appointed not only to do the clinical facilitation of students but also to act as the liaison person between the hospital and the nursing college. The clinical facilitator's job further includes the training of permanent staff. In other institutions offering nursing education, clinical facilitation is done by the nurse educator who teaches theory or by an allocated clinical facilitator. In South Africa, some provinces have introduced clinical instructors who, in addition to their role as clinicians, assist students in the wards (Botma, Jeggels & Uys 2012:2). The same model is currently being used in America, where facilitation of students is done by preceptors who have a dual role as clinician and facilitator in the units in which they are working (Weselby 2014:1). According to Taniyana, Kai and Takahashi (2012:1), in-service teaching of nurses involved in clinical practice differs from country to country.

Clinical facilitators facilitate the transfer of learning by acting as a bridge between theory and the reality in the clinical environment (Dahlke, Baumbusch, Affleck & Kwon 2012:692). Botma et al (2012:3) regard the role of the clinical facilitator to be the facilitation of learning in the hospital. These authors also explain that the clinical facilitator creates the setting that contributes to students' learning.

Uys and Meyer (2005:15), while affirming that, during facilitation, students are assisted to discover solutions on their own, also explain that facilitation is the accompaniment of students in the clinical field (Uys & Meyer 2005:12) and point out that various methods

of clinical accompaniment assist the clinical facilitator to facilitate critical thinking (Uys & Meyer 2005:16). Chappell (2016:2) emphasises the development of students by preceptors and mentors in order for them to learn foundational skills.

Transfer of learning must take place to ensure correlation between theory and practice. Clinical accompaniment is necessary for students to receive optimal training that will assist them in developing into competent, registered nurses. Better teaching of and learning by students in the clinical area will result both in better knowledge of nursing practice and, consequently, enhance clinical competency. Kaphagawani and Useh (2013:181) support this notion by adding that effective facilitation will prepare students for the future when they are to work as professionals. Nurses' clinical competency is significant to patient outcomes and affects the quality of the care they render. Tzeng (2003:491) agrees, saying that there is an association between the competency and functioning of a nurse. The author further states that the professional growth of nurses might advance nursing practice.

According to Botma et al (2012:3), a clinical facilitator has four main roles: orientation of the student, guided practice to assist students with their learning outcomes, formative assessment and role modelling of the nurse's role. The importance of this role should be validated by providing the clinical facilitators with sufficient time to prepare for their role before starting in this position (Andrews & Ford 2013:417). Cosme and Valente (2013:602) are of the view that clinical facilitators need training to be effective in teaching and learning. Once they have been selected and appointed in this particular position, clinical facilitators are often immediately expected to train students on the clinical component of their studies. These clinical facilitators often only undergo an orientation programme and are not subsequently mentored and guided during their first years in this position.

Because the effective clinical accompaniment and teaching of students in practice may potentially be enhanced by mentoring the clinical facilitators, this study has attempted to identify the mentoring needs of clinical facilitators.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Effective learning in the clinical setting is dependent on the interactions between students and their clinical facilitator ("learning guide") (Henderson & Eaton 2013:201). Gaberson and Oermann (2010:30) support the notion that the effectiveness of clinical accompaniment is evident from the extent to which it produces planned learning outcomes. In a study conducted by Zilembo and Monterosso (2008:201), the respondents viewed effective clinical facilitators as clinical nurse educators with interpersonal skills, which include communication skills, supportiveness and approachability in an encouraging working relationship. Sayers, DiGiacomo and Davidson (2011:49) acknowledge that a nurse educator's clinical competency alone is not sufficient to perform the duties she/he should carry out and they agree that adult-education principles are a required proficiency for a nurse educator. The clinical facilitator should therefore not only be a competent clinician but also be able to transfer knowledge to students. In a study by Bengtsson and Carlson (2015:7), the preceptors wanted more knowledge on teaching and learning strategies to be confident in demonstrating the required procedures to their students so that these students would be able to achieve their goals.

The effectiveness of a clinical facilitator lies in how well learning outcomes are achieved in order to fulfil the practical component of a nursing student's studies as required by the South African Nursing Council (SANC) through coordination and facilitation of learning (SANC 1985, R.425, para 6). Clinical facilitators require a number of skills to be able to do effective clinical facilitation. These facilitation skills could be taught through a formal clinical facilitation course or programme. Bengtsson and Carlson (2015:6) maintain that the essential components of such a programme should include "teaching and learning tactics, communication proficiency, reflective and critical thinking, [and] the duty and responsibility of the preceptor and preceptorship".

In a study by Myrick, Luhanga, Billay, Foley and Yonge (2012:1), clinical facilitators were prepared for their role of encouraging the best teaching practices in the clinical setting and of improving students' clinical experience. In South Africa, there are two courses for clinical facilitators, one being presented at the University of the Western Cape (a two-week-long course) and the other at the University of the Free State (three days, at one day per month for three months). These are for clinical facilitators to

prepare themselves for their role as clinical facilitators (Botma et al 2012:6). Some clinical facilitators attend the formal course in nursing education.

Clinical facilitators entering the clinical learning environment receive orientation in respect of their role. However, as part of their continuous professional development, they require a mentor to guide them through the process of adapting to reach a level of optimal functioning that will be to the benefit of both the students' learning and that of quality care. The mentoring process will assist clinical facilitators to understand and adapt to their role of clinical facilitation and to execute their role in such a way that it will impact positively on the learning outcomes students have to achieve. For this reason, clinical facilitators should not only be clinically competent but should also be able to create environments conducive to learning and provide learning opportunities for students to become lifelong learners (Sayers et al 2011:49).

Mentoring clinical facilitators could support them in the development of the required knowledge and skills of clinical facilitation with which to guide students through the process of clinical accompaniment. According to Byington (2010:4), a mentor (experienced clinical facilitator) can assist a mentee (novice clinical facilitator) in her/his development by providing direction to the mentee, by assessing the individual, and by being the example of what the mentee should live up to. The mentor and the mentee are part of the same peer group of clinical facilitators and should have common aims for the education and facilitation of students. Chichester and Dennie (2010:236), arguing in support of peer mentoring, maintain that peer mentoring will permit peers to share information in an unintimidated manner. Mentorship can thus be seen as an investment in that clinical facilitators are developed for the training of nurses by utilising the best possible clinical facilitation. Optimal clinical facilitation could assist towards the development of clinically competent nurses. Competent nurses will render appropriate nursing care, which, in turn, will enhance patient outcomes. The direct result of optimal clinical facilitation will therefore be quality care.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The quality of the nursing care rendered by nurses remains a matter of concern. One means of addressing this concern is to ensure the optimal clinical facilitation of students

up to the level of professional health care providers. Clinical facilitators therefore play an important role in respect of achieving this goal. Yamada and Ota (2012:229) acknowledge that the training done by a clinical facilitator enhances both the clinical performance and the socialisation of students into their nursing role.

Clinical facilitators play a crucial role in terms of applying theory to a real hospital setting. Forneris and Peden-McAlpine (2009:1716) confirm this by saying that clinical facilitators facilitate the transition of a nurse into professional practice by connecting theory with practice. Unfortunately, clinical facilitators are not always sufficiently competent or experienced in clinical education and facilitation to fulfil this role. Mannix, Faga, Beale and Jackson (2005:6) regard the inexperience of the facilitator to be one of the variables that have an impact on student learning. Clinical facilitators are clinicians (registered nurses) and not necessarily nurse educators who were appointed to facilitate clinical education in the hospitals. If a clinical facilitator is appointed to the position of a clinical educator this does not necessarily mean that this person is a skilled educator (Carlson 2013:470).

The mentoring of clinical facilitators could serve to develop effective clinical facilitation. The researcher was only able to locate two institutions with mentoring programmes for clinical facilitators in South Africa but could not verify that the mentoring of clinical facilitators is a known practice in the private health care setting. Yet, Eta, Atanga, Atashili and D'Cruz (2011:4) recommend that clinical facilitators be equipped with the necessary skills to enable them to teach effectively. Andrews and Ford (2013:417) found that the most valuable support that could be given to a novice clinical facilitator was to be mentored by an expert (senior) clinical facilitator. It is therefore a matter of urgency that the mentoring needs of clinical facilitators are explored with a view to developing a mentoring programme that will be able to support them in their role as a clinical facilitator.

Given the facilitators' lack of formal training or experience as clinical facilitators, the researcher identified the need to prepare clinical facilitators for their role.

1.4 PURPOSE AND OBJECTIVES OF THE STUDY

In order to address the perceived knowledge gap as regards the mentoring needs of clinical facilitators, it was imperative that this phenomenon be subjected to academic scrutiny.

1.4.1 Purpose of this study

The purpose of this study was to explore and describe the mentoring needs of clinical facilitators in order to propose a mentoring programme for effective clinical facilitation.

1.4.2 Study objectives

The objectives of the study were to:

- determine the existing mentoring initiatives that are available to clinical facilitators in the selected hospitals
- explore the mentoring needs of clinical facilitators in the selected hospitals
- develop an outline for a mentoring programme for clinical facilitators

1.5 SIGNIFICANCE OF THE STUDY

Support for clinical facilitators will result in better quality educational experiences for their students (McAllister, Oprescu & Jones 2014:248). The learning experiences of students in the clinical setting will enhance their commitment and their sense of responsibility in the nursing practice as nursing professionals. Responsible nursing professionals are sure to make a positive contribution to quality-based nursing care (D'Souza, Venkatesaperumal, Radhakrishnan & Balachandran 2013:30).

This study could be relevant to practice because exploring the mentoring needs of clinical facilitators could assist in developing a more structured approach towards improving the mentoring of clinical facilitators. By exploring the mentoring needs of clinical facilitators, a mentoring programme for clinical facilitators was developed to support clinical facilitators in their new role.

1.6 DEFINITIONS OF KEY CONCEPTS

1.6.1 Clinical facilitator and clinical facilitation

According to the Griffith University School of Nursing and Midwifery (2013:50) a clinical facilitator is a role model with the needed experience and knowledge to guide students and orientate these students to the profession and the workplace. In this study, *clinical facilitator* refers to a clinician who is appointed as the educator responsible for the clinical teaching and evaluation of students at the patient's bedside. *Clinical facilitation* refers to the role that a clinical facilitator has with regard to the teaching of student nurses at the patient's bedside.

In this study a *preceptor*, *clinical nurse educator* and *clinical facilitator* all refer to a clinical facilitator.

1.6.2 Mentee

A *mentee* is a novice who is being mentored by an expert during a mentorship process (Grove, Burns & Gray 2013:699). In this study, a mentee is a novice clinical facilitator who is being mentored by an experienced clinical facilitator.

1.6.3 Mentor

Grove et al (2013:699) describe a *mentor* as someone who teaches/counsels a mentee. In this study, a *mentor* refers to an experienced clinical facilitator who guides/mentors a mentee who is a novice clinical facilitator.

1.6.4 Mentoring

Mentoring refers to activities that are aimed at achieving a goal, career development and individual growth and which are compassionate, empowering and fostering (Wroten & Waite 2009:106). In this study, *mentoring* refers to the process whereby an experienced clinical facilitator, over time, guides or mentors a clinical facilitator who has less experience.

1.6.5 Student

A *student* is a person who is studying at a tertiary institution (*Oxford Learners Dictionary* [s.a.]). The South African Nursing Council (SANC) defines a student (learner) as someone who is registered with the SANC as a learner nurse or a learner midwife (SANC 2013, R.171, para 1). In this study, the term *student* is used when referring to student nurses and it signifies a person studying at a college of nursing to train as a nurse and who is registered with the SANC for this purpose.

1.7 RESEARCH APPROACH

For the purpose of this study, the researcher adopted a qualitative approach. Brink, Van der Walt and Van Rensburg (2012:11) explain that qualitative research investigates the qualitative aspects, experience and understanding of a phenomenon. Qualitative researchers use the evidence obtained from the data and literature to describe the phenomenon that is being studied. The researcher focuses on neither the size nor the numbers of the data, but rather the qualities (Henning, Van Rensburg & Smith 2013:30). The authors further state that qualitative research not only focuses on what happens but also on how it happens.

Qualitative research is conducted to explore and describe human experiences in a systematic manner (Grove et al 2013:23). For this study, the researcher decided on a qualitative approach to explore and describe the experiences of clinical facilitators. The lived experiences of the participants assisted the researcher to understand and identify the mentoring needs of clinical facilitators.

1.8 OVERVIEW OF THE RESEARCH DESIGN AND METHODOLOGY

In this section, a brief overview of the research design and methodology will be provided. The methods are to be discussed in detail in Chapter 2.

1.8.1 Research design

The research design of a study serves as a link between the research objectives (or questions) and the implementation thereof (Terre Blanche, Durrheim & Painter 2012:34). The researcher employed an exploratory, descriptive design for the study.

1.8.2 Population

The population for this study included all the clinical facilitators of a selected hospital group. Grove et al (2013:703) define a *population* as all elements that meet the inclusion criteria of a study. The accessible population from which the sample was drawn comprised the clinical facilitators working in the hospitals of the selected private hospital group in the Gauteng Province. The selected clinical facilitators were facilitating students in the group's hospitals during their clinical placement.

1.8.3 Sample and sampling technique

Sampling is the process of choosing participants for a study (Grove et al 2013:37). In qualitative studies, participants are selected based on their understanding of the phenomenon that is being studied (Streubert & Carpenter 2011:28). In this study, a non-probability, convenience sampling method, based on the specified inclusion criteria, was used to select participants.

1.8.4 Data collection

Data collection has to be performed in an organised, accurate manner that is appropriate for both the research purpose and the objectives of the study (Grove et al 2013:691). Focus groups were considered the most appropriate method of data collection and field notes were taken to capture the non-verbal communication of the group members during the focus groups.

Commencing with a grand tour question, unstructured focus groups were conducted. Probing questions were asked to elicit further discussion and to ensure that the focus of the study would be maintained. The conversations during the focus groups were audio recorded and field notes taken during and directly after the focus groups were used

during the data-analysis process. The field notes contributed to the richness of the data that were obtained.

1.8.5 Data analysis

Data analysis in qualitative research has a contemporary, emerging and linear progression (Henning et al 2013:6). The data analysis in this study was done in accordance with the step-wise scheme proposed by Terre Blanche et al (2012:322-326) and included the following steps:

Step 1 included *familiarisation and immersion* in the data during which process the researcher immersed herself in the data and brainstormed the data with her supervisor. In Step 2, *coding* involved that data were arranged into subcategories and then categories. During Step 3, the data were organised by *inducing themes* that naturally arose from the data. In Step 4 – *elaboration* – sections were compared and the data were considered as a whole rather than in parts. In Step 5, the data were *interpreted*. A detailed description of the data analysis is provided in Chapter 2.

1.9 ETHICAL CONSIDERATIONS

The principles of ethical consideration are based on participants' human rights that need to be protected. The researcher was interacting with clinical facilitators whose confidentiality needed to be protected. According to Streubert and Carpenter (2011:56), a researcher should consider that in qualitative research the possibility of unanticipated ethical dilemmas exists as a result of the nature of this method. Brink et al (2012:35-36) describe three ethical principles in the research process: respect for persons, beneficence and justice. In this study, the ethical principles and the imperative of the scientific honesty of the researcher were adhered to. A detailed discussion of these ethical considerations is to follow in Chapter 2.

1.10 TRUSTWORTHINESS

The imperative of trustworthiness was upheld by assessing the study in terms of the following concepts: credibility, dependability, transferability, confirmability and authenticity. Precisely how these concepts were applied will be described in Chapter 2.

1.11 OUTLINE OF THE DISSERTATION

The report of this study is divided into five chapters.

Chapter 1: Orientation to the study

In this chapter, the problem is introduced and the background to the problem is sketched. The research purpose, the objectives and the significance of the study are next discussed. The chapter further includes clarification of key concepts, an outline of the methodology, a description of the research design and of the ethical principles and the scope of the study.

Chapter 2: Research methodology

This chapter discusses the research design and details the methodology. The chapter further deals with the population, sampling, data collection and analysis. Trustworthiness, validity, reliability and ethical considerations are also discussed in this chapter**.**

Chapter 3: Presentation of the findings

This chapter is devoted to the data analysis and the findings pertaining to the data acquired by means of focus groups with clinical facilitators.

Chapter 4: Integrated discussion of the findings and literature

This chapter offers a discussion of the findings and integrates these with the existing literature on the mentoring needs of clinical facilitators so as to get an understanding of what is already known about this phenomenon.

Chapter 5: Conclusions, recommendations and limitations

Chapter 5 comprises the conclusions, recommendations and the limitations of the study.

1.12 SUMMARY

In this chapter, the researcher provided an overview of the study. The research problem, the purpose, the objectives and significance of this qualitative study have been explained. In the next chapter, the methodological aspects of the study come under consideration.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

Chapter 1 provided an explication of the study. The current chapter describes the methodological process that has been followed in this study. This entails the research design, population, the sample, the data-collection method, data analysis, trustworthiness and the ethical considerations.

2.2 RESEARCH PURPOSE AND OBJECTIVES

The research purpose is a statement that originates from the research problem, and assists the researcher in formulating the study objectives (Botma, Greeff, Mulaudzi & Wright 2010:287). The purpose of this study was to explore and describe the mentoring needs of clinical facilitators with a view to developing a mentoring programme for effective clinical facilitation. The following objectives were set to realise the purpose of the study: (1) to determine what mentoring initiatives are currently available to clinical facilitators; (2) to explore the mentoring needs of clinical facilitators; and (3) to develop an outline for a mentoring programme for clinical facilitators.

2.3 RESEARCH DESIGN

A research design is the unique map that is used to plan and carry out a study (Grove et al 2013:214). The research design should be suited to a study, and it should describe the advantages and disadvantages of the method to be utilised (Botma et al 2010:283). The use of appropriate methods are sure to increase the likelihood that the study outcomes will be true reflections of reality and this will consequently enhance the validity of a study (Grove et al 2013:214). A qualitative, exploratory, descriptive study design was used.

2.3.1 Qualitative research

A qualitative approach investigates a chosen phenomenon by attempting to understand the reality from an emic perspective of enquiry rather than explain it by means of controlled measurement. Qualitative research requires a holistic orientation in respect of examining a phenomenon in its entirety (Grove et al 2013:25). Qualitative research is undertaken when little is known about a phenomenon (Waltz, Strickland & Lenze 2010:225) and will contribute to the understanding of the phenomenon (Botma et al 2010:182). Waltz et al (2010:225) explain that qualitative research is an approach that both describes a phenomenon and also creates meaning in respect of a phenomenon experienced by an individual. In this study, the researcher was interested in the emic perspectives of the clinical facilitators.

Using the qualitative approach allowed the researcher to explore and understand the human experience from the clinical facilitators' point of view regarding their own mentoring needs. An exploratory design contributed towards understanding the nature and the extent of the mentoring needs of the clinical facilitators. The exploratory research was combined with a descriptive design to describe the mentoring needs that clinical facilitators identified during focus groups.

Because qualitative research is also characterised by a belief in multiple realities and in-depth knowledge of the phenomenon, the viewpoints of participants were explored by means of an unstructured data-collection approach to elicit different viewpoints and multiple realities of how the clinical facilitators in this study experienced their mentoring needs.

2.3.2 Explorative research

The purpose of exploratory research is not to generalise the findings to a large population but to add to the body of knowledge in a certain discipline (Grove et al 2013:370). Explorative research is often used to develop knowledge in a new area that is being studied, to generate new ideas about a phenomenon or to test the feasibility of a more comprehensive study of the phenomenon. Explorative studies are also used when little is known about the phenomenon to be studied (Botma et al 2010:185). The researcher chose this design because mentoring programmes for clinical facilitators

seem not to be common practice in all hospitals and nursing education institutions. The exploratory approach assisted the researcher in gaining insight into the lived experiences of clinical facilitators and their mentoring needs.

2.3.3 Descriptive research

When studies are descriptive, they are usually accurate descriptions of experiences that help to explain a phenomenon (Botma et al 2010:185). A descriptive study was therefore considered to be appropriate to this research because this study was aimed at understanding the mentoring needs of clinical facilitators. During the focus-group interviews, the participants described their experiences as clinical facilitators and their mentoring needs.

2.3.4 Research setting/context

This study was conducted in the hospitals associated with a nursing college within the selected private hospital group in Gauteng. Students of the nursing college are placed at these hospitals for the clinical component of their studies.

2.4 POPULATION

Population refers to the group on whom the researcher bases her/his conclusions (Babbie 2014:119). The population for this study were the clinical facilitators working in the hospitals of a private hospital group in Gauteng. These clinical facilitators are entrusted with facilitating the students of a private nursing college who are placed at the hospitals for the clinical component of their studies. Clinical facilitators accompany these students in clinical practice. They facilitate and evaluate clinical outcomes to ensure that these students are competent. Some facilitators are not only responsible for the clinical facilitation of students but they also have other duties to perform in the hospitals.

2.4.1 Accessible population

The accessible population refers to the people who will be available for the study (Brink et al 2012:208). The clinical facilitators working in hospitals in Gauteng were the

accessible population for this study. This gave the researcher access to the participants to be able to conduct the focus groups.

2.4.2 Eligibility criteria

Eligibility criteria refer to the characteristics that a participant must have to be included in a study (Grove et al 2013:353). Eligibility criteria for this study included:

- All the male and female clinical facilitators
- The clinical facilitators facilitating students of a nursing college

2.5 SAMPLE AND SAMPLING

This section describes the sample and the sampling methods used in this study. A sample refers to a smaller part of the larger population selected by the researcher to participate in a research study (Brink et al 2012:131-132). The sample was taken from all the clinical facilitators working for the selected private hospital group.

2.5.1 Sampling

Sampling refers to the method that sets apart a portion of the population that represents the assessable population (Botma et al 2010:124). To be able to select a sample from the population, the researcher needs to have a list of people in the population. This is referred to as the sample frame of a study (Grove et al 2013:357). The private nursing college whose students are doing the clinical component of their studies at the hospital has a list of the clinical facilitators who are facilitating students in the hospital. The list of clinical facilitators working in the selected hospitals was obtained from the manager of the Learning Centre at the private nursing college that sends its students to the hospital where the clinical facilitators are working. The researcher made use of the list to enable her to contact the participants via email and invited them to participate in the study.

2.5.1.1 Non-probability sampling approach

In non-probability sampling, not everyone in the population will be included in the sample. (Grove et al 2013:362). To select a sample for this study, a non-probability sampling approach and a convenience sampling method were used.

2.5.1.2 Convenience sampling method

Convenience sampling is based on the availability of participants (Waltz et al 2010:215). A convenience sampling technique was chosen for the selection of participants for this study because there were a limited number of possible participants and the researcher was dependent on the availability of the participants.

2.5.2 Sample size

According to Grove et al (2013:371), there is no hard and fast rule with regards to sample size in qualitative research. However, arbitrarily choosing a convenient sample of participants could produce misleading results. The sample size is therefore determined by data saturation. Data saturation transpires when no new information is obtained from supplementary sampling (Grove et al 2013:371). The researcher identified that data saturation had been reached after three focus groups when it became evident that no new themes were emerging and when the previously collected data were being repeated. A total of 16 participants took part in the focus groups.

2.6 DATA COLLECTION

Data collection refers to the accurate, orderly gathering of information pertaining to the purpose, the objectives and the research questions (Grove et al 2013:45). A qualitative data-collection method puts the researcher in a position to understand feelings, experiences and social situations as they transpire in the real world (Terre Blanche et al 2012:287). The participants had first-hand experience of clinical facilitation. The researcher explored the lived experiences of the clinical facilitators pertaining to their own mentoring needs and aimed to create an understanding of these needs. In qualitative research, interviewing is a method of data collection that is done in a much more natural form (Terre Blanche et al 2012:297). According to Babbie (2014:329),

focus groups are interviews conducted in a group. In this study, data were collected by means of focus groups to enable the researcher to understand the lived experiences of clinical facilitators.

Focus groups

Focus groups are conducted in groups (Babbie 2014:329) and, because they include interaction, they are considered to be a powerful means of exposing reality among participants who often share the same experiences and feelings (Stommel & Willis 2004:301).

The researcher believed focus groups to be the best method of data collection because they would yield the richest data possible for this study. In contrast to individual responses, focus groups – because of their collective nature – tend to be more elaborative (Fontana & Frey 1994:365). Terre Blanche et al (2012:304) state that when focus groups are used, access is gained into the intersubjective experiences of a group. The experiences of intersubjective groups include not only the experiences shared by a group (commonalities) but also their differences.

Three focus groups were conducted. In the first focus group, there were five participants, five in the second group and six in the third group. The number of participants in a group can affect the outcome of the focus group. Babbie (2014:329) indicates that a focus group can consist of between five and fifteen people. Whereas too few people in the focus group may limit the potential interaction between participants, too many participants may, on the other hand, inhibit the participation of all the participants (Hancock, Windridge & Ockleford 2007:22). The number of participants in each focus group were not too few, neither too many and allowed participation of all the members. To ensure the participation of all members during the focus group, the researcher gave all of the participants an opportunity to respond.

2.6.1 Pre-testing of focus groups

A pilot study refers to an initial focus group that assists with the identification of possible problems in respect of the design and the instruments (Terre Blanche et al 2012:94). A pre-test focus group was conducted using a group of four participants. The members of

this focus group had similar characteristics to the participants who were to be used in this study. During this group session, the grand tour question was asked to pre-test it for understandability of the question, the researcher's facilitation skills during a focus group were monitored and the suitability of the venue for conducting focus groups was assessed. Prior to a focus group, the researcher asked the participants to complete the consent and demographic data form. Upon completion of the focus group, the participants, the researcher and the co-facilitator discussed the processes that had taken place, the clarity of the consent form and also the grand tour question.

Being a novice researcher, the researcher asked a co-facilitator to attend the pre-test focus group. The facilitator and the co-facilitator had a discussion after the pre-test focus group and talked about what they had learnt from the session.

The researcher learned the following from the pilot focus group: (1) participants should be positioned in a circle and not in a square to ensure that all participants are able to see one another to facilitate participation in the group; (2) to prevent distraction, consent forms should be collected before the focus group commences and not left on the table in front of participants; and (3) before the grand tour question is asked a more inclusive background to the study should be provided to the participants for them to understand the grand tour question in context.

2.6.2 Data-collection process

The data-collection process by means of focus groups will be discussed in this section. Data collection is described as a precise collecting of data that is applicable to the research objectives and purpose (Grove et al 2013:691). Data collection in qualitative research is done by studying and recording human conduct or by conducting interviews (Terre Blanche et al 2012:51).

2.6.2.1 Planning

According to Grove et al (2013:274), a successful focus group is effectively planned. The researcher's planning included finding a venue where the focus groups could be held. Two focus groups were held in the library at an identified nursing college and the third in a classroom. The library and the classroom were booked well in advance of the

date of the meeting. On the invitation, the researcher indicated the estimated duration of the focus group. According to Grove et al (2013:275), the estimated duration of a focus group should be between 45 and 90 minutes. The 15 minutes before the commencement of the focus groups were used to collect the demographic data and obtain individual consent. Terre Blanche et al (2012:304) maintain that a focus group has four essential components: procedure, interaction, content and recording. These four essential components are discussed below.

2.6.2.2 Procedure

The procedure of the focus group refers to the setting of rules prior to the focus group (Terre Blanche et al 2012:305). The researcher established the rules prior to the commencement of the focus group. Three specific norms were to be adhered to: firstly, to ensure confidentiality, no member would discuss any conversations that had taken place during the focus group; secondly, to prevent any disruption during the focus group, all mobile phones had to be switched off; and thirdly, the participants were asked to allow all members of the group to participate in the focus group.

2.6.2.3 Interaction

Interaction refers to the interpersonal interaction inside the group (Terre Blanche et al 2012:305). The researcher introduced an ice-breaker that required the participants to introduce themselves to the group. This served to enhance group participation and put the group members at ease.

2.6.2.4 Content

Content refers to what is spoken about or done during the focus group (Terre Blanche et al 2012:305). A grand tour question was asked to elicit the participants' views on mentoring and probing questions were asked during the focus group to facilitate conversation. The grand tour question was: "What are your mentoring needs as clinical facilitators?" All the participants were given a chance to participate and to engage in group activities. Genuine interest and enthusiastic participation characterised the focus group. Bless, Higson-Smith and Sithole (2013:200) note the following advantage that was also experienced in this focus group, namely that participants are able to discuss

the phenomenon with one another. Discussion during a focus group activates ideas. When the views and ideas of participants are shared with the group, this might lead to the development of new or more ideas (Streubert & Carpenter 2011:38), which could lead to a deeper understanding of the phenomenon. It was however apparent that most of the senior facilitators participated less enthusiastically than the rest of participants. Some members tended to take over. When given a chance to talk in the group, they would launch into lengthy explanations of their own experiences. The researcher however facilitated the discussion so that all participants in a group could take part. A disadvantage of focus groups is that the strong participants in the group might control and dominate the group. Streubert and Carpenter (2011:38) maintain that the researcher can overcome this disadvantage by constantly bearing this potential problem in mind. This problem was indeed experienced in one of the focus groups when some participants continued talking for long stretches without giving the rest of the participants an opportunity to air their views. The researcher was aware of this disadvantage and would allow other participants opportunities to participate in the discussion. Another disadvantage is that some participants in the group might be excluded if the facilitator is an inexperienced facilitator (Bless et al 2013:217). The researcher avoided dominance/exclusion by giving all participants an opportunity to participate in the discussion. The researcher made eye contact with those participants who indicated that they wanted to say something. This gave the participant a non-verbal indication that the researcher was listening to her/him and inviting her/him to participate in the discussion.

2.6.2.5 Recording

According to Terre Blanche et al (2012:307), the proceedings of a focus group are usually written down. During the focus groups the co-facilitator took field notes. The researcher also made notes directly after the focus group had ended. Notes were made of participants' non-verbal communication, which, together with the recordings, enhanced the researcher's understanding of the phenomenon.

2.7 DATA ANALYSIS

Qualitative data analysis is a non-numerical method that is used to understand observations that determine essential meanings and patterns (Babbie 2014:403). Terre Blanche et al (2012:322-326) identify five steps in the data-analysis process:

familiarisation and immersion, inducing themes, coding, elaboration and interpretation, and checking. Data were analysed using these five steps:

Initially, an external transcriber transcribed the focus group from the voice recordings made during the focus groups. In all, six computer folders were created: one for each focus group recording (total of three) and one for each transcription of the recordings (total of three). The researcher first listened to the recordings of the data before reading the transcribed data to determine whether the transcriptions were indeed verbatim transcriptions.

The researcher subsequently listened to the recordings in order to do data cleaning. The data cleaning was done by making notes on printed copies of the transcribed data. Because the transcriber was not a nurse, she was unfamiliar with some nursing terms used in the focus groups. During the data cleaning, the researcher corrected some of these nursing terms in the transcribed data. One of the abbreviations used during one of the focus groups were ENA (enrolled nursing assistant). The transcriber used the word GA and is an example of the words that needed to be corrected. Parts of the recordings were inaudible which complicated the transcription process. The researcher, who personally heard what had been said during the focus groups, was able to understand the bigger context of the discussion which limited the gap in the data. During this step of data analysis, the researcher started to immerse herself in the data and to reflect on the relationships of the collected data. The researcher was able to familiarise herself with the data by reading and re-reading the transcriptions.

When a researcher immerses her-/himself in the collected data, she/he is immediately able to see when new data are added and themes are repeated. This assists the researcher in determining when data saturation is attained (Bless et al 2013: 342).

Once she had immersed herself in the data, the researcher started with the preliminary coding process. Words and phrases with the same meaning were identified and given a specific colour and was marked with a highlighter. This assisted the researcher in grouping the data. Bless et al (2013:342) explain that when data saturation is reached, the researcher will notice a set of codes identified during the preliminary process, which addresses the research question.

Rather than use a software programme, the researcher preferred to do the data analysis manually. Meaning units marked with the same colour were cut out and posted on a board. From these meaning units subcategories emerged. The researcher explored the subcategories more closely, the aim being to capture the subtler nuances of meaning from the data grouped and coded together. The reason for investigating the subtler nuances of meaning of the data was to ensure both that the researcher would give a good report of what emerged from the data analysis and that categories could be formed from the subcategory. The categories resulted in patterns in the data and these patterns were given a collective name referred to as a theme (Annexure 7). Four themes emerged from the data. The four themes were: need for support, preparation as clinical facilitator, role clarification and sense of responsibility.

The field notes were also analysed and integrated with the focus group data. Most of the field notes identified the emotions that the participants had experienced during the focus groups and provided more information regarding their lived experiences.

To ensure that the researcher would code the data correctly, the researcher did an inter-coder reliability check. A co-coder was appointed to code the data. The coding results of the researcher and those of the co-coder were compared and then discussed with the supervisor. The final themes, categories and subcategories were then agreed on.

The inter-coder reliability check was followed by the interpretation of results. The researcher described the themes, categories and subcategories that she had identified with her supervisor. The discussions of the participants were described and the researcher drew attention to areas containing similar statements and to those containing contradictory ones.

2.8 TRUSTWORTHINESS OF THE STUDY

The validity of a study is influenced by the manner in which a study was carried out and refers to the trustworthiness of the findings (Smith 2015:257). The researcher ensured that trustworthiness was attained by appraising the research in terms of the following concepts: credibility, dependability, transferability, confirmability and authenticity.

2.8.1 Credibility

Bless et al (2013:236) maintain that credibility considers whether the research findings of the phenomenon under scrutiny makes sense and complies with the requirement of internal validity. The researcher wished to ensure both that the data could be trusted and that there was precision in the interpretation of the data. Botma et al (2010:233) refer to the following strategies as methods that ensure credibility: prolonged engagement, reflexivity on the part of the researcher, triangulation, member checking, group discussion, authority of the researcher and negative case analysis.

The researcher established confidence in the results by utilising some of these strategies. Firstly, the researcher had *prolonged engagement* in the field of clinical facilitation a*s* she had been appointed as a clinical facilitator herself for a period of nearly nine years*.* She could therefore be said to understand clinical facilitation as such. This however placed a specific responsibility on the researcher to ensure that she would bracket her own experiences. The term *bracketing* means momentarily to forget about everything we know and feel about the phenomenon. In essence, this means taking care that our predetermined ideas and thoughts do not get in the way of obtaining data that are free of manipulation (Terre Blanche et al 2012:322). According to Streubert and Carpenter (2011:27), bracketing is a cognitive process of setting aside one's own ideas. Bracketing was done in this study by having various frank discussions with the study supervisor about the topic and about her own experiences of clinical facilitation. These discussions allowed the researcher to air her own views and to vent her concerns regarding the topic, thereby allowing herself to go into her data-collection and data-analysis process with an open mind. Her engagement during the considerable time she spent conducting focus groups gave her an in-depth understanding of the phenomenon.

Member checking was yet another method used to increase credibility. The findings of the study were presented to the participants to ensure that the interpretations that had been made, accurately reflected their views and that the data analysis mirrored their ideas so that the findings would be a true reflection of their descriptions during the focus groups. The findings were presented to the participants through electronic communication. A file containing the themes and categories allowed the participants to review the findings. The members responded, indicating that they were in agreement

with the findings that had been sent to them and they indicated that they had nothing to add.

Negative case analysis was employed to search for any information that contradicted the findings in the study (Babbie 2014:349). The researcher searched for academic articles that refuted the findings of the study. While some of the articles refuted the findings of the study, others supported them. Most of the articles however supported the findings of the study. More will be said about this in Chapter 4.

Although the researcher was personally responsible for collecting the data in this study, she employed bracketing by not using her own ideas and refraining from using her background to draw conclusions. She collected and subsequently reflected only the data that were communicated in the focus groups by the participants. No data were selectively included or excluded and findings were reported in an honest manner. No data were fabricated of falsified. This contributed to the *researcher credibility* of the study.

2.8.2 Dependability

Dependability refers to the reliability of data over time and in different settings (Polit & Beck 2012:585). The researcher utilised the method of *inquiry audit* to establish the dependability of this study. The inquiry audit implies that an audit trail had to be kept. An audit trail refers to a detailed account that is kept of all the research procedures (Lietz & Zaya 2010:198). The researcher collected, recorded and transcribed the information in respect of the collected data and the field notes as precisely as possible. The researcher listened to and read through the transcribed data to make sure that the transcriptions were a true reflection of what had been recorded. The researcher familiarised herself with the data by reading and re-reading the data.

2.8.3 Transferability (applicability)

Botma et al (2010:233) describe applicability as the extent to which research results can be applied to other groups and to larger populations. The researcher established applicability by giving as much information about the context as possible. When thick descriptions of the study are provided, readers will be able to decide whether this study

is transferable to their environment. Triangulation is another means by which the transferability of a study can be determined. Triangulation refers to the use of multiple research methods to test similar outcomes in a study (Babbie 2014:121). The researcher ensured data triangulation through collection of data by using both focus groups and field notes in a single investigation. The researcher also made use of a co-coder and conducted a literature control to check the findings of this study against existing knowledge.

2.8.4 Confirmability

The researcher ensured confirmability by discussing the steps and the logic of the methodology with the study supervisor. The researcher used this method to justify why she was opting for a specific methodology. Confirmability was also validated through an audit trail of the actions and of all the evidence in the study over time. The researcher recorded all the actions and kept all records to ensure that evidence would be available regarding how the findings were confirmed. According to Streubert and Carpenter (2011:49), recording of the findings will leave a track of the progress of the study.

2.8.5 Authenticity

Authenticity refers to the extent to which the researcher is able to demonstrate the realities and experiences of participants (Polit & Beck 2012:585). To ensure that authenticity was upheld in this research, the researcher included the direct quotations of the participants in the data analysis. The non-verbal communication recorded in the field notes was included when the data were presented.

2.9 ETHICAL CONSIDERATIONS

Research ethics places considerable emphasis on how research participants will be treated in a study (Bless et al 2013:28). Institutional permission and ethical principles will be discussed in this section.

2.9.1 Institutional permission

Institutional review boards review all research proposals to guarantee that the participants' rights will be protected (Babbie 2014:73). Institutional permission was obtained from Unisa and from the particular private hospital group.

2.9.1.1 Ethical clearance process

After the development of the research proposal for the study, the researcher submitted the proposal to the Research Ethics Committee of the Department of Health Studies at Unisa and was given ethical clearance to conduct the study (Annexure 1).

2.9.1.2 Institutional permission

Review boards consider all proposals in which human participants are involved so as to ensure that the participants' rights and interests are protected (Babbie 2014:73). After the ethical clearance certificate had been obtained from the university, the researcher submitted the proposal and the abstract of the study to the Institutional Ethics Review Board of the private hospital group at which the study was to be conducted. The Institutional Ethics Review Board granted permission for the study to be conducted in the particular private hospital group (Annexure 2).

Institutional permission was also obtained from each one of the hospitals at which the focus groups were to be conducted. Letters to ask permission were sent to the hospital managers of the hospitals at which the clinical facilitators were working to ask that the latter be allowed to participate (Annexure 3). The hospital managers gave the researcher written permission to proceed with the proposed study (Annexure 4).

2.9.2 Ethical principles

Streubert and Carpenter (2011:56) maintain that ethical matters should be considered in all research that is conducted. Brink et al (2012:35-36) identify three ethical principles that should guide researchers. These three ethical principles are respect for people, beneficence and justice.

2.9.2.1 Respect for persons

Respect for people refers to the right to self-determination and the treatment of participants as self-directed agents who have the freedom to choose (LoBiondo-Wood & Haber 2014:256). Bless et al (2013:30) hold that autonomy as the choice that a person has as to whether to participate in a study. Informed consent was therefore obtained from the participants to affirm their right to autonomy in this study.

Informed consent is the confirmation given by participants that they will participate in a study after they have been given all the important information about the study (Grove et al 2013:697). Streubert and Carpenter (2011:61) add that the participant should know what the benefits and possible risks of a study are before informed consent is given.

The researcher introduced the participants to the research activities of the study by explaining the purpose of the study and its long-term significance for clinical practice. The participants were informed who the study population were and why they had been selected to participate. It was explained that a focus group is the data-collection method. Although privacy and confidentiality cannot be guaranteed, these participants were ensured that their privacy and confidentiality would be respected at all times, and that data would be processed in such a way that discussions will not be linked to a particular person. The rules of the group were discussed at the start of each focus group and entailed that the participants agreed to keep everything that was discussed in the group confidential. This was also captured in the audio recording as proof that the confidentiality between the members was addressed. The individuals were informed that they could either refuse to participate or withdraw without penalty and that they could withdraw from the study at any time. The participants then gave informed consent to participate in the study (Annexure 5).

2.9.2.2 Beneficence

The principle of beneficence refers to protecting the individual from discomfort and harm (Brink et al 2012:35). Although it was not foreseen that participants would suffer any discomfort or be harmed in any way in this study, the researcher adhered to this principle by treating the focus group in such a way that would allow all participants to participate and also to respect the contributions of other individuals without being exploited.

Although the researcher is employed in the head office of the institution, her position is not linked to clinical facilitation. The researcher always guarded against any bias and thus ensured that her focus remained squarely on the objectives of the study.

2.9.2.3 Justice

Brink et al (2012:36-37) assert that any agreements with the participants should be kept. The participants were treated fairly and the researcher therefore commenced the focus group on time and terminated the group within the approximate timelines provided to the participants. The comments of participants were respected and treated in a non-prejudice manner.

A researcher should also protect the privacy of the participants and the institutions (Brink et al 2012:37). Data collection took place in a private setting with a closed door that created a secluded area where the participants could talk freely. Transcripts were locked away for confidentiality purposes. Neither the institution nor the participants' names were mentioned in the research report so as to ensure confidentiality. This process was also followed in respect of the data. The participants' identities were not divulged in the reporting of this study, and shall not be made known when the outcomes of this study are published. This means that no connection can be made between the data and the participants. The above processes honour the principles of privacy, anonymity and confidentiality.

2.10 SUMMARY

This chapter outlined the methodology employed in this study. This study was a qualitative study involving focus groups. The main aim of the study was to explore and describe the mentoring needs of clinical facilitators so as to put the researcher in a position to develop a mentoring programme for effective clinical facilitation. The objectives, the research design and the population were described. The sampling process, the data-collection method and the process of data analysis were discussed. This chapter also addressed the issue of trustworthiness and dealt with the ethical considerations pertaining to the study. The findings that are based on the collected data will be discussed in Chapter 3.

CHAPTER 3

PRESENTATION OF THE FINDINGS

3.1 INTRODUCTION

In Chapter 2, the researcher described the methodology used in this study. Chapter 3 provides a discussion of the findings based on the data obtained by means of focus groups and field notes. After discussing the demographical profile of the population, the researcher turns to an explication of the themes, categories and subcategories that emerged from the data. Verbatim transcriptions have been used to support the coding of the data.

3.2 DATA ANALYSIS

The data-analysis method proposed by Terre Blanche et al (2012:322) was followed to analyse the data. Initially, the researcher familiarised herself with the data by reading the transcribed notes while listening to recordings of the focus groups. Coloured highlighters were used to cluster together similar words, sentences and paragraphs with similar meanings. Meaning units were cut out and posted on a board. Data with the same colours were grouped together and sometimes data were moved between colours until the researcher was satisfied with the fit of the data. Subcategories emerged from the meaning units and were followed by the elaboration of general concepts to identify similarities and differences between these concepts to form categories. The categories were grouped together and were given a collective name – generally referred to as a theme – that resonated with the meaning of the data. The researcher interpreted and checked the data for contradictions and also reflected on her own objectivity during the data-collection process.

3.3 FINDINGS

3.3.1 Demographical details

The biographical data reflect the participants' gender, age, qualifications, special courses in clinical facilitation and their experience of working as a clinical facilitator.

Sixteen participants were included in the three focus groups. Whereas fifteen of the participants were females, only one was a male. Bleich, MacWilliams and Schmidt (2015:89) stated that there is a gender imbalance in nursing and that female nurses are in the majority. True to the current situation in the nursing profession, most of the participants were over the age of 40. The aging population in nursing is cause for concern in that while experienced practitioners are aging, very few young nurses are available to take over the role of experienced, expert clinicians. Matt, Fleming and Maheady (2015:325) indicated that the nursing workforce to be aging.

In this study, most of the participants had fewer than five years of experience in the field of clinical facilitation. Furthermore, only one of the participants had done a course in clinical facilitation and just more than half of the participants had a formal nursing-education qualification. Not all of the clinical facilitators were formally equipped for this role.

3.3.2 Themes, categories and subcategories

Themes, categories and subcategories emerged from the data. The data described the clinical facilitators' mentoring needs in respect of the effective execution of their role as a clinical facilitator. The themes that emerged from the data collected during the three focus groups are reflected in Table 3.1.

Table 3.1: Themes

Theme 1:	Need for support
Theme 2:	Preparation as clinical facilitator
Theme 3:	Role clarification
Theme 4:	Sense of responsibility

3.3.2.1 Theme 1: Need for support

This theme is based on the support needs of clinical facilitators. They described their need for support that would help them to do their work. One participant had the following to say about the difficulty of not having support:

> "There was nobody that I could ask, please just help me because I am really drowning."

The need for a mentor to help participants when they start out as clinical facilitators was evident in the following comment:

> "So mentoring, I really need mentoring in so many levels. Not only to, not handle but to work with the students, but everything that is going around with the administration parts, the knowhow of everything."

Participants articulated that the support from a mentor would help them to find their feet in this role more quickly:

> "... if you have to find your own way it is going to take you a bit longer to get there, whereas if somebody can tell you and show you, you actually get up and running[run] much quicker".

McAllister et al (2014:247) hold that a mentoring relationship between a novice and an expert will ensure a rapid transition from clinician to educator.

The categories under this theme were the *orientation and learning needs of a clinical facilitator, emotional support* and *the attributes of a mentor.* Table 3.2 indicates the categories and subcategories of Theme 1.

Table 3.2: Theme 1: Need for support

Theme	Category	Subcategory
Need for support	Orientation and learning needs of a clinical facilitator	Absence of a mentor who could identify needs
		Availability of a mentor to identify needs
	Emotional support	
	Attributes of a mentor	Knowledgeable
		Supportive

3.3.2.1.1 Category 1: Orientation and learning needs of a clinical facilitator

The participants reported that they needed a mentor who would be able to identify their learning needs. One participant expressed the need for a mentor in the following manner:

> "A mentor is somebody who have [has] travelled the road. So, she knows all the aspects, or almost all the aspects of the job. The mentor will know my needs ..."

The participants expressed the need to have orientation when entering the position as clinical facilitator:

> "When I was appointed I didn't get orientation. So, I was put in the position, given students and left to just swim."

Another participant stated:

> "Obviously, as were stated, we are put in the position. There is no formal training. I think an orientation programme of some kind in terms of what is your responsibility, what are the skills you need to apply in the field and also in terms of you formal orientation. I think that is one element which sometimes misses because sometimes the hospitals are pressed on, they want somebody to just get [go] and do the work."

A participant who had not received any orientation when she started in her new role was neither ready nor prepared for what lay ahead:

> "I did not know about all the pitfalls lying in front of me. The only thing that kept me standing is the fact that I was so motivated to teach and to make a difference in nursing, I did not know about all the pitfalls lying in front of me."

Though the participants were clearly looking for guidance, they did not want to be told how to do the work, but only what was required of them:

> "It is not teaching me how to do things, it is telling me what I need to do, what is required of me, what deadlines do I have and how I do it."

The participants indicated that they were given no guidance as to how to find their feet or how fully to understand their role:

> "So ... it was also sometimes with trial and error as well. Up till now we don't have clear ... if they tell us look for a policy, and you will be searching and searching and searching because it is not given to you."

The lack of a formal orientation programme is a matter of concern. Cangelosi, Crocker and Sorrell (2009:370) state that not having a formal orientation programme creates frustration among novice clinical nursing educators.

Subcategory 1: Absence of a mentor who could identify needs

Participants indicated that, although identified, their mentoring needs were not being met and that they had to find their own way in clinical facilitation. Said one participant:

> "So, at the moment, I feel a little bit on very shaking ground and very, very deep waters because I got [have] all these [this] information from everyone, but no one can actually say to me you know what you are doing this right or no you are not doing this right: because we don't actually have anybody that we can ask where we are at the moment."

The participants further said that they would like a person or different individuals (each a specialist in her/his own field) to be identified who could act as mentors to novice clinical facilitators:

> "I think there should be a lifeline. If I need this, I can phone this one; if I feel like maybe this, then this one can help. Today I will phone you but next week I want to phone you."

However, during the discussions it became apparent that only a few participants were actually fortunate enough to have a mentor to guide them and address their mentoring needs. One of the participants even said that she had not seen a person who would be able to mentor clinical facilitators:

> "So far, I don't think I have seen ... that person."

Subcategory 2: Availability of a mentor to identify needs

The participants described the considerable benefits attached to having a mentor to support them in their new role: their mentor had helped them find their feet during the orientation phase. These mentors were more experienced peers who had not formally been appointed as mentors.

One participant described how her mentor had prepared her for her new role:

> "... she also prepared me for that because she said to me all the … you know, every job has its positives and negatives. She said to me, "Listen, this is the negative part of it …" So she told me before it happened. So, I was sort of prepared when things did happen."

Another participant who had a mentor said the following:

> "I have been really privileged to be mentored by a very special lady ... Yes, being exposed to what she was doing, I could ask the questions ... You need to be exposed to the situation or the field to be able to know what to ask, because I will not know whether I know it or not if I am not exposed to where I must be."

3.3.2.1.2 Category 2: Emotional support

The new role of a clinical facilitator can be stressful and can potentially put an individual through considerable emotional pressure. At stages during the focus groups, the participants were very emotional as they indicated their lack of a support system. One participant explained how she experienced the emotional element of working with people:

> "There is a lot of emotion, now that I am thinking about it. You are working with a lot of, you are working with people."

This would suggest that the participants felt that they needed to be emotionally supported.

Another participant referred to the emotions experienced by the clinical facilitators. At times during the focus groups, this specific participant was very emotional and

explained that even in a classroom situation she was not able to distance herself from the emotions she felt for her students:

> "Also, I have got kids very similar … the same age as my students. So, I have that mom component. You cannot distance yourself from your own emotions. Even in class, while in contact, it is difficult."

Carlson (2013:237) concurs that clinical facilitation takes place in a stressful environment in which students with different knowledge and skills levels have to be accommodated and that the clinical facilitator should be able to create a learning environment for her students that bridges theory and practical knowledge. Clinical facilitators should therefore receive emotional support in the stressful environment in which they find themselves.

3.3.2.1.3 Category 3: Attributes of a mentor

When participants were asked about the characteristics of good mentors, they highlighted two traits, namely to be knowledgeable, that is, to have the requisite skills and to be approachable:

> "I am not being nasty saying it, but reinforcement from somebody that hasn't got the skill doesn't actually mean anything."

St George and Robinson (2011:24) stated that a mentor has to support a novice in many different roles: as a mother, a friend, a counsellor, a protector, an advocate, an adviser, a listener and a reality checker.

Cangelosi (2014:328) argues that, even with formal training in education, nurses need guidance on how to apply these practices in teaching. This finding resonates with a statement from one of the participants:

> "If you have [a] mentor that you can just sit and talk to, one that has been in education for years, for me that would be nice."

Subcategory 1: Knowledgeable

In the transition process from being a nurse to a nurse educator nurses need to be prepared by a knowledgeable person. To be an effective nurse educator one needs both clinical expertise and the knowledge to translate clinical knowledge into educational material (McAllister et al 2014:243). Mentors should also support mentees in order for them to refine their nursing expertise, and to think and handle situations like professionals (Reid, Hinderer, Jarosinski, Mister & Seldomridge 2013:289).

The participants felt that they had been clinicians for a long time, but when they entered into the new role of clinical facilitation, they had many questions that they would have liked a knowledgeable mentor to answer. One of the participants articulated the general feeling:

> *"*Although you are in nursing for more than twenty years now and you are asking this question, she doesn't let [make] you feel stupid about it, and the fact that she is knowledgeable."

The participants expressed the need to learn from people who had sufficient knowledge and experience in clinical facilitation:

> "So maybe if you have the opportunity to sit in with your more experienced people and see how they do it so that you can take from that ..."

The participants moreover felt that mentors should be people who had gained their experience over a period of time:

> "A mentor is somebody who have [has] travelled the road."

This Garr and Dewe (2013:250) state that a mentor should be an expert who is knowledgeable and who is able to give direction.

Subcategory 2: Approachable

Being *approachable* means that the mentor should be both open and available to novice clinical facilitators (Garr & Dewe 2013:250; Killam & Heerschap 2012:689). The participants expressed a need for a mentor to whom they can freely talk. This implies that the mentor has to be approachable. Said one participant:

> We still need that one person that we can actually talk to and say, "You know what … what are we doing … are we doing something wrong?"

Another participant voiced her need to have a person to reach out to, a person one would feel comfortable about contacting:

> "So it is … there isn't someone that you can reach out that is really close, that you can just quickly, you know ..."

3.3.2.2 Theme 2: Preparation as clinical facilitator

The findings point to a significant need for preparation as a clinical facilitator to assist with the transition from clinician to clinical facilitator. The participants expressed a need for a holistic approach to be followed in preparing them for clinical facilitation. They also identified the need to engage in future formal studies to obtain the relevant qualifications for their role as a clinical facilitator.

The three categories identified under this theme were: *learning by trial and error, teaching skills and holistic approach to clinical facilitation* (see Table 3.3).

Table 3.3: Theme 2: Preparation as clinical facilitator

Theme	Category
Preparation as clinical facilitator	Learning by trial and error
	Teaching skills
	Holistic approach to clinical facilitation

3.3.2.2.1 Category 1: Learning by trial and error

The lengthy discussion on having to learn by trial and error proved to be extremely emotional. Participants' uncertainties regarding their ability to support students effectively surfaced during this discussion:

> "So, by trial and error I started to work out for myself a system. If I don't know even now if it is right but it is working for me."

Participants' confusion was further compounded by the realisation that their facilitation was not always correct:

> "I think you learn by trial and error because you make your own mistakes. But sometimes your mistakes actually cost the students or the staff member because you are learning at the same time."

A clinical facilitator should be well prepared for her role. However, according to Andrews and Ford (2013:417), clinical facilitators can never be fully prepared for their role as a clinical facilitator. These authors maintain that starting out as a clinical facilitator might be experiential by nature and that the clinical facilitator will develop as time passes. The participants in this study realised that their role would also entail experiential learning:

> "You need to be exposed to the situation or the field to be able to know what to ask, because I will not know whether I know it or not if I am not exposed to where I must be."

3.3.2.2.2 Category 2: Teaching skills

The participants were concerned about being equipped with knowledge of the different teaching strategies and learning styles and about not knowing how to facilitate learning that would suit all learning styles. One of the participants had the following to say about her teaching skills:

> "Now who am I that are [am] not sure that am I correct? I can show her my ways and how I do it, and how I swam to the, for the resolution. But I don't feel that I didn't have

> the correct backup. Am I leading the blind leading the other one, or am I doing a good, or am I actually not? "

The participants were concerned that their lack of knowledge of teaching and learning styles would affect the learning of their students. One participant admitted:

> "... it is difficult for me sometimes to decide what strategy I need to implement to help another person to get where I want them to be."

The participants also indicated that they needed to be prepared in order for them to continue to be relevant in the current nursing environment:

> "You got your opinion from your educator. You were taught this is the way that that [things] gets done. Today everybody has a say. Our country has changed. The way things are done has changed. So is our skill relevant for the generation? But that is not the worst. I have got three generations in one class."

Weidman (2013:102) asserts that the transition from clinician to educator is very difficult if a person does not have previous teaching experience.

According to the SANC, the nursing education qualification prepares nurses to teach students both in the classroom and in the clinical setting (SANC 1987, R.118, para 6[d]). In this study, more than half of the participants (see Section 3.3.1) had formal training in nursing education. The participants nonetheless felt that the training had not prepared them for the clinical facilitation role that they now had to fulfil. Clinical facilitators are clinicians who have been appointed to teach the clinical component of nursing. Some kind of education is required to assist them in their role as an educator. One of the participants pinpointed the problem:

> "… Remember, we are not teachers ... Okay we have one year of education behind us, which didn't taught me much."

Participants identified the need to be prepared for their new role as a teacher. When people are clinically skilled, it does not necessarily mean that they have teaching expertise (Spencer 2013:15). The latter author further argues that the clinician might

know what to teach but does not know how to teach. The participants in the present study mentioned that they sometimes made mistakes and that their students "suffered" as a result. An obviously disconcerted participant shared the following with the group:

> "Yes, I feel some of them I failed … some of them. Not because I wanted, but because of a lack of knowledge ... now that they have qualified I have the need to go back and teach them because I didn't do it right."

Participants stated that the current nursing education programme did not fulfil their needs. They needed more practical support in terms of showing them how to teach:

> "So how to teach isn't part of the curriculum or part of that training structure that they have. That was one of my needs: How do I get there? How do I implement? How do I teach ...?"

The participants indicated that they not only wanted to be trained on the theory of education but also needed to be taught how to implement what they had been taught:

> "Because it is one thing again to read it in a book and it is another thing to see it."

Weidman (2013:106) claims that if nursing schools continue to appoint clinicians as educators without having taken courses in education, challenges in the transition process will continue. She also maintains that there should be a transition and a mentoring process to assist the newly appointed educator. However, even if courses in nursing education are recommended for clinical facilitators, the needs of clinical facilitators are not in alignment with what is taught at the university in nursing education programmes to enable them to do their work:

> "Now, the education they taught you in the university and what you actually need to do in practical is totally two different stuff [things]."

3.3.2.2.3 Category 3: Holistic approach to clinical facilitation

The participants wanted a more holistic approach to clinical facilitation. By being trained in a holistic manner, they would be better prepared to facilitate learning in a holistic

manner. The participants felt that they needed a better understanding of the human component and that they should have the tools to support students because everyone does not have the same skills in facilitating students:

> "I am also feeling very strong that we need that people skills and I think some people have more of them naturally that others. But it is always a bonus if you can get more skills regarding that aspect of handling with people because you work with different personalities, different levels of emotional intelligence and maturity."

Participants did not feel prepared to approach the facilitation process in a holistic manner, at different levels and in different domains, which includes the psychosocial domain:

> "My issue is when you manage the student. There is a human part ..."

According to Killam and Heerschap (2012: 684), the clinical facilitator should recognise the challenges that students face in the clinical setting. All the factors that could potentially impede student learning should be considered. Learning processes (including contextual and individual factors) might have an effect on students' learning experiences and the learning outcomes they have to achieve (Tuomi, Aimala, Plazar, Starčič & Žvanut 2013:692).

In addition, the participants wanted to be prepared to motivate students and although this was not mentioned by many of the participants during the focus groups, the researcher felt that it was significant in the holistic preparation of a clinical facilitator. One participant mentioned that motivation is part of the role of a clinical facilitator:

> "How do you motivate somebody? What is the psychology behind teaching?"

One of the group members who became very emotional about not being able to motivate a student stated that motivation should come from within. Kusurkar, Ten Cate, Van Aperen and Croiset (2011:252) maintain that educators should create a learning environment in which autonomous motivation can be stimulated. They further hold that autonomously motivated students experience greater satisfaction and lower stress and

are less susceptible to burnout. Clinical facilitators should therefore shift their focus from how to motivate a student to creating a supportive learning environment for students to become autonomously motivated.

3.3.2.3 Theme 3: Role clarification

Clinical facilitators have many roles to fulfil. The participants also expressed their frustration at not really knowing what the requirements of their position were. In any position there should be clear role clarification so as to ensure optimal functioning. Clinical facilitators should know what the institutional expectations are and what is expected as regards the students. When the roles of clinical facilitators were discussed, there were many different views. Strong views were aired:

> "There are so many divided roles."

> "... they will give you maybe ten things in your job description which is actually not exactly what you are doing."

> "This is what you think you have to do, and then when you are in the role there is added to it."

One of the participants also indicated that she did whatever needed to be done in the hospital so that her roles kept increasing:

> "So, I am everything."

It seemed that participants' job requirements were not clearly stipulated and that they were consequently not sure what they were actually supposed to do on a day-to-day basis. One of the participants said in this regard:

> "It is really frustrating to how [know how] to do something and not really knowing [I do not really know] what is my job requirements. Not really knowing am [I do not really know] [if] I [am] doing it right, [or] am I not doing it right."

At this stage of the discussion, the researcher had to probe and facilitate the discussion carefully to ensure that the focus was not lost. The participants continued talking about

the many roles they have and placed major emphasis on this discussion. The participants experienced these numerous roles as challenging.

Yamada and Ota (2012:236) assert that if the roles of clinical facilitators are clarified, this will result in less uncertainty regarding their responsibilities. Because of the broadened role of clinical facilitators, the role expectations should be streamlined so that both clinical facilitator and management will understand the role of the former.

The many roles that the clinical facilitators had to fulfil in the hospitals overshadowed their role as an educator in the clinical component of nursing education. In the hospitals, they were utilised in other roles. This statement of one participant described the view of their role taken by the hospital/business:

> "We train in a company that is not pro education. That is the reality. But we need to survive around that reality to make sure SANC is happy and to make sure that they have a good product and to make sure … It is difficult, but that is the reality. We are not educators, not for business."

Table 3.4 outlines the two categories identified under the theme of role clarification: a feeling of *powerlessness* and one of *role conflict.*

Table 3.4: Theme 3: Role clarification

Theme	Category
Role clarification	Feeling of powerlessness
	Role conflict

3.3.2.3.1 Category 1: Feeling of powerlessness

The participants voiced their feelings of frustration, of having no authority, of being marginalised and of being lonely that all resulted in feelings of powerlessness.

Clinical facilitators did not belong to a specific group:

> "But, again, it is a lonely journey."

They were moreover excluded from certain aspects:

> ".... we are there but we are on the side."

Because there was no clear role clarification, the clinical facilitators became frustrated and experienced limitations.

> "So, it is very frustrating because you want to do something. It is also difficult to know where is you limitations, how far must you go. So, it is quite frustrating. It is quite limited [limiting]."

The participants expressed their feelings of not having any authority in the hospital in the following manner:

> "But as a CTS [clinical facilitator] you have not [no] authority to go and sit ... or even if you give very kindly advice to that specific unit manager it is not always taken up seriously."

3.3.2.3.2 Category 2: Role conflict

Role conflict refers to being 'torn between' two or more different roles. Role conflict occurs when a person has roles that are not clearly delineated. In this study, the participants experienced their role as clinical facilitators in the hospital environment as conflicting as they had a responsibility towards their students but also towards the hospital management:

> "I must keep the student happy; I must keep the college happy; I keep the hospital happy."

Experiencing role conflict creates a situation in which the facilitator will not be effective in the many roles she/he has to fulfil.

In spite of having to fulfil diverse roles in the hospital, clinical facilitators are still socially removed from the clinical practice group. One participant emphasised their need to belong to a group:

> *"*Where do you really fit in?*"*

In addition to all the roles clinical facilitators had to embrace, the participants often had to assume managerial responsibilities in the hospital. When the managers had their Christmas party, the clinical facilitators were not included and they were excluded from the strategic planning sessions:

> "Are you a manager? ... We didn't go for strat [strategic] planning for nursing. We didn't go. They left me in charge of the hospital and say [said] you run the hospital."

Adding to their frustration was the fact that, on the one hand, they had to take responsibility for managerial tasks while, on the other, they were not regarded as managers.

Feelings varied from being lonely through to having no authority to having no support. The participants were also frustrated because of the many roles they had to fulfil and the little support from management. The participants felt that they have not mastered their roles as clinical facilitator yet and did not always know how to balance their different roles:

> "I still feel after a year and a half in this position I am juggling fifty balls in the air and I am not doing one very well."

> "... you need to do everything. Where do you start?"

3.3.2.4 Theme 4: Sense of responsibility

It was evident from the findings that the participants felt responsible for their own ability and also the student outcomes. They considered the student outcomes to be a reflection of their ability to teach the student. They believed that they were responsible

when the students failed or when the outcomes were negative. Two categories were identified: *own ability* and *student outcomes.*

Table 3.5: Theme 4: Sense of responsibility

Theme	Category
Sense of responsibility	Own ability
	Student outcomes

3.3.2.4.1 Category 1: Own ability

Participants felt that they were responsible for their own abilities. While they never stated that they were responsible for positive student outcomes, they did feel responsible for having failed some of the students because of their own inadequacy.

> "Because I am not standing for myself, I am standing for other people as well."

The participants felt that they should have the ability when they start out in this position:

> "I cannot expect my hospital to have [a] backup because I am a specialist, so I should know."

They expressed feelings of failure because their lack of knowledge had prevented them from assisting the students. One participant had the following to say in this regard:

> "... I feel some of them … I failed some of them. Not because I wanted, but because of a lack of knowledge."

3.3.2.4.2 Category 2: Student outcomes

The student outcomes make it evident that the participants feel responsible for the outcomes of the student and, ultimately, the quality of nurse who is being trained. The nurse whom she/he trains will be a representative of nursing care and this places an enormous responsibility on the shoulders of clinical facilitators. The following comment illustrates their views:

> "... it feels like the whole training thing of the whole hospital sits on my shoulders alone; so, if the quality goes down a little bit, I feel responsible."

The participants also mentioned that their abilities were often compared with the previous performances of other colleagues:

> "So the expectation is, am I going to create the same product as everybody before me?"

Even if the clinical facilitators feel responsible for the student outcomes, the literature states that transformation from a student to a professional is the collective responsibility of the clinical facilitators and the hospitals. This is reflected in the study conducted by Yamada and Ota (2012:236), who maintain that nurse managers should support clinical facilitators and share responsibility for the clinical training of students with the clinical facilitator.

3.4 SUMMARY

This chapter both presented and discussed the data obtained by means of focus groups. Four themes were identified, discussed and supported with quotes from the transcribed data. In the next chapter, the findings will be discussed and integrated with the existing literature related to the phenomenon under investigation.

CHAPTER 4

DISCUSSION OF THE FINDINGS AND THE LITERATURE

4.1 INTRODUCTION

Chapter 4 discusses the findings of this study and integrates these with the existing literature on the mentoring needs of clinical facilitators. The aim of the literature review was to contextualise the study findings within the existing body of knowledge. By integrating the findings and the existing literature, new insights were gained by the researcher.

There were various phases in the integration of the literature. These included the selection of sources that address the phenomenon under investigation and that were regarded to be relevant in terms of synthesising the findings. A literature search was done by using the following search engines: ProQuest, EBSCOhost and Google Scholar. Terms and phrases related to the title and objectives of the study and the themes that emerged were used to search for relevant literature.

4.2 NEED FOR SUPPORT

The need for support was discussed in different ways. The data that were obtained emphasised the significance of identifying the needs of clinical facilitators. The participants identified the need for mentoring to support clinical facilitators when they start out in their new positions. Clinical facilitators should be supported during their transition from clinicians to clinical facilitators by affording them opportunities to share their expectations and by giving them practical knowledge of how to plan and execute clinical learning and manage complex situations with students (Reid et al 2013:290). According to Gilbert and Womack (2012:101), an expert's ability to encourage, support, coach, direct and mentor a novice will determine just how successful the latter will be.

The participants agreed that orientation would support clinical facilitators when entering their new role. They felt that if better orientation were provided, they would know what to do and what was expected of them. From the findings it is evident that the participants

had not been effectively orientated. Without the necessary orientation into their new environment and role, novice clinical facilitators will not know what is expected of them. Not knowing the expectations set for one's role creates uncertainty which could result in under- or poor performance.

4.2.1 Orientation and learning needs of a clinical facilitator

In a qualitative study conducted by Nottingham (2015:306) involving athletics-training preceptors, the participants described their experiences when starting out in this new role. They explained how they had been able to contact peers and mentors to assist them and how these relationships had served to support them in their new role. The process that was followed in Nottingham's study differed significantly from the one followed in the current study. Only some of the participants in the current study reported that they had contacted their peers for assistance. In addition, no identified mentors had been allocated to the participants in the current study. The participants moreover identified the need for more than one person to mentor them. These mentors had to be experts in their field and able to provide mentoring in their areas of specialisation. Wroten and Waite (2009:106) state that, depending on the needs of the individual, a person can be mentored by different individuals.

Mentors play a vital role in the orientation of mentees. Gilbert and Womack (2012:101) state that formal orientation is relevant in terms of promoting successful role change from expert nurse to clinical nurse educator (clinical facilitator). In a study among new school teachers by Israel, Kamman, McCray and Sindelar (2014:62), the authors confirmed that a mentor plays a critical role during the orientation of a novice teacher. In their study, two senior staff members were allocated to orientate teachers in a two-day formal orientation programme. The programme continued with a monthly mentoring session of one and a half hours between the novices and the experts. These sessions took place in an informal setting over lunch so as to socialise and speak about their experiences as teachers. After the informal discussion, a few practical issues around academic outcomes were discussed. This study by Israel et al (2014:62) included an orientation programme followed by a mentoring programme. Although this study focussed on teachers in a schooling system the same needs were also identified by the clinical facilitators in the current study where it was found that novice clinical facilitators seldom undergo orientation. An orientation programme that is linked to a mentoring

programme could address both the orientation and mentoring needs of clinical facilitators.

Seekoe (2014:6-7) is of the opinion that mentoring will encourage the reflective practices of mentees and allow them to develop. Seekoe (2014:7-8) identifies four steps in the mentoring process that will assist mentees in developing the requisite competencies: relationship building, development, engagement and the reflective process:

4.2.1.1 Relationship building

In this step, the mentee and mentor agree to work together to achieve a mentoring outcome. Mentoring takes place within a framework of trust and respect (Clark 2015:109). This stage also includes agreeing on the rules and expectations that frame the relationship. As the participants did not have mentors, this relationship-building phase was absent in the current study.

A lack of mentors raised the question as to how the participants in the current study had developed competence in their new role without having adequate support from peers and mentors. Garr and Dewe (2013:251) assert that mentoring provides input for the personal and professional growth of individuals. To a large extent, the success of mentees thus depends on the mentors who facilitate orientation and provide mentoring (Gilbert & Womack 2012:101). In a mentoring relationship, the mentee should however demonstrate a willingness and an eagerness to learn (Clark 2015:109) and should reach out to others should she/he want to be mentored (Clark 2015:110). In a study by Straus, Johnson, Marquez and Feldman (2013:7) the authors identified the factors that could contribute to failed mentoring relationships, namely poor communication, a lack of commitment, personality differences, competition, conflicts of interest and the mentor's lack of experience.

4.2.1.2 Development

In this phase, the strengths and limitations of the mentee are determined. This stage is characterised by conflict and a power struggle between the mentor and the mentee. Although this was not evident in the current study (that lacked mentoring relationships),

one of the participants in the current study gave a very good example of what could transpire during this stage when she said: “But I don’t think that is what the mentorship goal should be. It is not teaching me how to do things, it is telling me what I need to do, what is required of me, what deadlines do I have and how I do it.”

4.2.1.3 Engagement

During the engagement phase, the mentor will be a role model, speak to the mentee and support and guide the mentee. Those participants in the present study who had indeed enjoyed the support of a person (mentor) indicated that they had been better prepared for their new position.

4.2.1.4 Reflective process

By this time in the orientation process, the mentor has developed the mentee. The mentee now uses various strategies to reflect on her/his practices. The mentee is empowered to utilise self-inquiry, which will therefore be strengthened in the process. Mentoring assists individuals to make better decisions and to improve their actions (Raisbeck 2012:51). Mentees who have been mentored efficiently might display self-directedness in their own learning. In a study conducted in Isfahan among clinical nurses to assess the activities for self-directed learning, Ghiyasvandian, Malekian and Cheraghi (2015:54) established that knowledge acquisition and skills development are key to self-directed learning. Clinical facilitators should be self-directed learners who identify their own needs and direct their own learning. The data reflect that the clinical facilitators in the present study are not self-directed in their own learning. If clinical facilitators are not self-directed in their own learning, this is bound to influence how they train their students in that they will be unable to mentor their students to become self-directed learners.

4.2.2 Emotional needs

Effective clinical facilitation is reliant on the emotional commitment of clinical facilitators (Msiska, Smith & Fawcett 2014:49). Emotional commitment may cause strain on clinical facilitators and they need emotional support in the working environment in which they find themselves. Furthermore, it became evident that clinical facilitators need

interpersonal skills to deal with their students on a daily basis. Besides their studies the students were also human beings, and their psychosocial status might have had an enormous effect on their achievements. According to Zakrzewski (2013:1), who has been a full time school teacher for seven years, teachers should develop social-emotional skills to improve the welfare of both the student and the teacher by cultivating self-compassion and self-awareness. She stated that she had no remaining emotional capacity when she left teaching because of her lack of social and emotional skills during her teaching career. Zakrzewshi's reflections (2013) could be related to clinical facilitation because of the teaching role a clinical facilitator has to fulfil.

4.2.3 Attributes of a mentor

The two essential attributes that the participants in this study required of a mentor are those of being knowledgeable and approachable. Participants expressed their need for a mentor who has been in a clinical facilitator's position for a substantial number of years. They felt that the person should have knowledge and the ability to mentor them. The participants have been clinicians and experts in their field of practice. Even with their extensive knowledge as clinicians they were now novices and needed a mentor who would be approachable and did not make them feel inadequate. Wroten and Waite (2009:106) maintain that mentors should excel at providing support, be able to direct and should moreover have proven success in the area in which they intend to mentor someone. Straus and Sackett (2012:368) support the notion that a mentor should be someone who has achieved significant successes and commands considerable respect. In addition, mentors should be approachable and be a supporter rather than a moderator so that the mentee will be free and open to the mentor's input (Straus & Sackett 2012:368). In addition to what was found in the current study, Castiglioni, Aagaard, Spencer, Nicholson, Karani, Bates, Willett and Chheda (2013:137) established that effective mentors are expert communicators who listen and give remedial advice.

Garr and Dewe (2013:247) caution that mentoring should be done by a person who is not in a supervisory role because this might influence the connection between the two individuals. Using peers to mentor novice clinical facilitators might therefore be a better course of action than using supervisors as mentors.

4.3 PREPARATION AS CLINICAL FACILITATOR

Though the development of students featured prominently in the participants' responses, their own development was identified as an even more pressing need. They needed more knowledge about clinical facilitation skills so that they could develop their own capacity as clinical facilitators. Being a knowledgeable clinical facilitator could positively benefit the students one teaches. Andrews and Ford (2013:413) maintain that a clinical facilitator, just like any other practitioner, needs to develop in their role. The participants in the present study also explained that they had embraced their role as a clinical facilitator by teaching and applying their own ways of teaching by trial and error and had sometimes done so to the detriment of their students when these methods had failed.

4.3.1 Learning through trial and error

Clinical facilitators reported using trial and error as a teaching method. In the trial and error method, the clinical facilitator uses methods from her/his own experience as a student. Myrick et al (2012:6) state that clinical facilitators draw from their own experience of what they were taught when they were students, but the authors also caution that if they want to teach students, they need a new understanding of the clinical facilitator's role. Drawing from one's own experience as a clinician or student will not adequately equip one for a clinical facilitator's role. Clinical facilitators should be able to identify their own learning needs and the areas in which they need to develop. This relates to being self-directed. According to Van Rensburg and Botma (2015:2), nurse educators (clinical facilitators) need to develop as self-directed learners in order to develop their students as independent learners because self-directed learners will be more effective in their role. The paradigm shift to self-directed learning has not yet occurred and didactic education remains the main method of teaching since educators (clinical facilitators) have a tendency to teach students in the same way they were taught (Guglielmino & Toffler 2013:10).

The findings indicate that the participants have not taken responsibility for identifying their own needs so that they may grow as professionals. Clearly, they considered management to be responsible for their professional development as clinicians, leaders and managers. It is expected that clinical facilitators will be self-directed in their learning

and moreover able to identify their own development needs in respect of professional growth.

4.3.2 Teaching skills

The participants expressed their views on the learning needs of clinical facilitators and preparation for their new role. To ensure the effectiveness of clinical facilitators, both their knowledge and guidance needs should be identified. (Dahlke, O'Connor, Hannesson & Cheetham 2016:145). McAllister et al (2014:246) acknowledge that learning and development are required so as to assist clinical facilitators in their new role. The authors describe these developmental needs as new skills, knowledge and cultivating the attributes of an educator.

Jetha, Boschma and Clauson (2016:3-5), in a systematic review, identify three evidence-based needs in respect of identifying and supporting novice clinical facilitators. These needs are socialisation, professional development and the need for self-reflection and confidence. These correspond to some of the needs that were identified in the current study. *Socialisation* is related to the isolation that clinical facilitators experience. *Professional development* is related to the support needs of clinical facilitators and focuses on the orientation and feedback that is required by clinical facilitators to develop in their new role. *Self-reflection* refers to the clinical facilitator's ability to identify her/his own learning needs.

Another sentiment expressed by the participants concerned their learning needs in respect of teaching strategies and the learning styles of the students. A study by TakkaçTulgar (2015:213) with novice educators to determine their needs in the induction process indicated that the participants needed mentors to observe them while they were teaching, the idea being that the presence of mentors would potentially assist the mentees to learn new teaching strategies. One of a clinical facilitator's main responsibilities involves being able to utilise the appropriate teaching strategies. Using the appropriate teaching strategy will support and encourage individuals to become more self-directed facilitators (Cadorin, Suter, Dante, Williamson Devetti & Palese 2012:157).

The participants also voiced their need for didactic guidance to support the students' learning. This relates to the fact that only 56% of the participants had a tertiary qualification in nursing education. According to Dahlke et al (2012:696), clinical educators would rather base their teaching on their own clinical practice than on formal educator training. In a study by Cangelosi (2014:327) involving novice nurse educators who had formal teaching training, participants articulated the need for mentoring. It was however noted that those participants who had acquired a formal qualification in nursing education demonstrated more resilience in their professional situation despite there being a lack of structure Cangelosi (2014:328).

The existing education qualifications of clinical facilitators were found to be non-supportive in terms of their roles as clinical facilitators. The participants felt that the qualifications in nursing education failed to meet the needs of clinical facilitators with regards to enabling them to fulfil their teaching role. It was indicated that the needs of clinical facilitators did not sufficiently align with what was being taught in the nursing education programmes of universities to enable them to do their work. The qualification in nursing education currently taught at universities does not meet the educational needs of clinical facilitators because they do not know how to implement these teaching skills in practice. Similar findings were obtained in a study by Chang, Lin, Chen, Kang and Chang (2015:225) in which the perceptions of nursing preceptors regarding a preceptor programme were explored. The nurse preceptors (clinical facilitators) felt that the training course was impractical. Taniyama, Kai and Takashashi (2012:1) point out that, in Japan, a clinical facilitator's role is seen to be so important that the appointment of such a person will only be made once she/he has five years' clinical experience to her/his credit and has done 240 hours of training sessions in preparation for the role of clinical facilitator. However, even with extensive preparation, these clinical facilitators found it difficult to handle some of the aspects of clinical facilitation. The difficulties in the Japanese study are by no means unique and were also prevalent in the current study. Because some aspects can only be learnt once the facilitator has been appointed and is actually working as a clinical facilitator, it is difficult to prepare a clinical facilitator exhaustively to perform optimally in her/his new role prior to starting out in the role.

4.3.3 Holistic approach

The need to approach students holistically was identified as an important learning need when clinical facilitators were being prepared. The participants mentioned that they lacked interpersonal skills when working with students. They wanted to be able to assist students holistically in achieving their clinical skills as well as in their emotional and social needs and be able to motivate students through their studies. According to Hilli, Salmu and Jonsén (2014:569), students will feel cared for if clinical facilitators treat them as individuals and welcome them as part of teams in units. This is cause for concern because one of the participants indicated that she was unable to distance herself from her emotions. The relevant literature indicates that the relationship between a clinical facilitator and a student should be caring, supportive and focused on student learning outcomes (Hilli et al 2014:570). Clinical facilitators should therefore ensure that they do not expand their role by becoming involved with students who are struggling emotionally. The participants further stated that they found their job draining because they had to do other things apart from attending to student-related issues (rendering emotional support to students).

4.4 ROLE CLARIFICATION

The participants were not provided with job descriptions and this gave rise to frustration and uncertainty among these clinical facilitators. Conway and Elwin (2007:189) carried out a study with hospital-based clinical nurse educators to investigate the shared identity and roles of a clinical nurse educator. They reported that there should be a shared understanding of the roles and functions of those who are in educational roles in nursing.

4.4.1 Feeling of powerlessness

The main factor described by the participants was a feeling of powerlessness. Participants believed that lack of support in their work from management had an effect on their work and that this probably gave rise to a feeling of powerlessness: “But people has [have] got this rigid mindsets of doing things that does [do] not always benefit the student, and then you have to do that.” The same participant added that the clinical facilitator should be a buffer between the student and the institution. The inability to

meet the unique needs of each student as well as the institutional needs often results in a feeling of powerlessness.

Participants also depicted their job as a lonely journey. According to McAllister et al (2014:246), professional isolation can lead to low morale and that linking nurse educators with one another could help to dispel feelings of isolation. Jetha et al (2016:3) state that isolation can be alleviated by addressing the following three needs: the need “to be accustomed to a new situation”, the need “to belong” and the need “to connect with students”. The authors suggest that a clinical facilitator should connect with other individuals in the teaching community to become accustomed to the new situation and thus lessen isolation.

4.4.2 Role conflict

In addition to the facilitation role, clinical facilitators are also expected to fulfil other roles in the hospital. The participants agreed that because this is so, the student is no longer the primary focus of clinical facilitation. According to a study done by Kalischuk, Van den Berg and Awosoga (2013:37), clinical facilitators should understand their role and responsibilities, what they know and what they need to know. Clinical facilitators should understand what they are expected to do and what the roles are that they should fulfil. This idea is also reflected in the study by Yamada and Ota (2012:235) who state that if there is no agreement and clarity regarding the role of a clinical facilitator, this places a burden on the clinical facilitator that will result in stress and compromise the efficiency of the clinical training that is received. When clinical facilitators are required to fulfil so many roles, they become ineffective teachers. In the study by Kalischuk et al (2013:37), the participants indicated that they would be more efficient as teachers if their workload were reduced.

The participants viewed themselves as employees who did not feel that they were part of the hospital team. They felt that they did not receive the support they needed and perceived that the hospital management did not view their role as important. Penkala (2015:6) maintains that, to ensure the future of health professionals, the placement of students in the clinical setting for education should be seen as the heart of the business in the health services. It is therefore important that management, especially, should value the clinical placement and facilitation of students to ensure a sustainable future for

their hospitals. However, in order for management to understand the value that clinical facilitators add, the clinical facilitators must ensure that they themselves are competent in their role.

The participants stated that, although they were also being used as managers, they did not enjoy the same benefits enjoyed by managers. One participant complained that though she was excluded from the strategic planning of the hospital and the year-end function of the Heads of Department, she had to run the hospital while the managers attended these sessions and functions. No literature could be found to validate the role of a clinical facilitator as a manager. However, various authors reported that they are regarded as leaders. Adelman-Mullally, Muller, McCarter-Spalding, Hagler, Gaberson, Hanner, Oermann, Speakman, Yoder-Wise and Young (2013:33) assert that clinical facilitators' leadership potential can assist transformation in nursing education by means of student interaction. Good leadership skills are important attributes in nursing and students imitate these from their clinical facilitators to become good leaders themselves.

4.5 SENSE OF RESPONSIBILITY

While participants accepted their responsibility toward their students, they failed to see a direct responsibility toward their patients. They also doubted their own competence in imparting knowledge to the students.

4.5.1 Own ability

The participants were anxious about the possibility of providing inadequate or incorrect knowledge, thereby hypothetically affecting students' potential to become good nurses. Participants indicated that they wanted to develop good nurses and did not want to harm them. They moreover felt responsible for their own teaching ability. In a study by Omer, Suliman and Moola (2015:59), the authors point out that the focus should not be on student outcomes but rather on clinical facilitators' considerable responsibility as regards protecting patients against mistakes made by students. The participants in the present study never mentioned the importance of protecting patients through the facilitation of students. This is alarming because the primary focus should always be the safety of the patient first.

4.5.2 Student outcomes

Having a sense of responsibility could mean one has to take ownership. The participants maintained that they felt responsible for student outcomes. The participants believed that when students failed, the clinical facilitator was to blame for the poor outcomes. However, the clinical training of a student is a collective responsibility shared by the clinical nurses (working at the bedside) and the clinical facilitators. Mannix, Wilkes and Luck (2009:66) claim that the factors that will influence the outcomes of clinical training in the nursing unit will be the training that is done by the clinical nurse at the patient's bedside and also both the ability and knowledge of the clinical facilitator.

4.6 SUMMARY

In this chapter, the findings and literature were integrated. The findings of the study were contextualised in terms of the existing literature. The conclusions, recommendations and limitations of this study will be discussed in the following chapter.

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

In the previous chapter, the literature and the findings of the study were integrated. In this chapter, the conclusions will be discussed under each of the themes so as to explain how the objectives of the study were achieved. The objectives of this study were to:

- determine the existing mentoring initiatives available to clinical facilitators in the selected hospitals
- explore the mentoring needs of clinical facilitators in the selected hospitals
- develop an outline for a mentoring programme for clinical facilitators

The recommendations and conclusions will serve as guidelines for addressing the mentoring needs of clinical facilitators.

5.2 CONCLUSIONS DRAWN FROM THE MAIN FINDINGS

Four themes were identified by means of focus groups. The identified themes are relevant to the mentoring needs of clinical facilitators. From the findings it can be concluded that the objectives of the study were achieved.

5.2.1 Impact of demographic data

The participants were between 30 and 60 years old. Most of them were older than 40 years. This is in line with the current aging nursing population of above the age of 40. This aging population is not a new phenomenon Buchan (1999:824) stated that the aging of nurses and growing numbers of nurses in their 40s and 50s were a concern. In a more recent study Kwok, Bates and NG (2016:500) confirm that the nursing population is aging which increases the pressure on the healthcare system with its growing demands. This remains a point of concern as the aging nursing generation will

also have an effect on the experts who have to date been in clinical facilitation positions and who will be retiring in a few years' time. This will leave very few experts and mentors in the field to assist novice clinical facilitators to develop in their new role. Novices are currently drawing knowledge from experts who have been in their facilitation roles for many years.

5.2.2 Need for support

Although no formal mentoring programmes were available to novice clinical facilitators in the institution in which the study participants were working, peer-to-peer mentoring that transpired proved to be of value. Some of the participants however reported that they had been mentored by more experienced peers. Those who had been exposed to such mentors indicated that this had given them the opportunity to ask the right questions.

While Maya, Kamman, McCray and Sindelar (2014:62) maintain that it is important that mentoring be included in the induction programme of a novice, Schoening (2013:171) suggests that mentoring should be an integral part of any orientation programme. Therefore, to support them in their new role, novice clinical facilitators should be exposed to an orientation programme that is followed by a mentoring programme. The participants stated that they had not been adequately orientated in respect of their new role and consequently felt that they did not know what was expected of them.

It is clear that clinical facilitators need emotional support and, to be effective clinical facilitators, they should also develop social-emotional skills. This will not only lead to the creation of an improved learning environment for students but will also result in the enhanced well-being of clinical facilitators.

The participants described a mentor as a person who should be supportive and approachable. The participants indicated they would like more than one mentor who is a specialist in their respective fields. The mentors should assist mentees so that the mentees will be able to understand how to prioritise and fulfil all the roles of a clinical facilitator. It would be ideal if mentors were to be identified from among the clinical facilitators and then trained as a mentor by means of a formal mentoring programme.

Conclusion statement: Theme 1 − Need for support

The findings of this study indicate that the needs of the clinical facilitator are directly linked to the need for orientation and mentoring.

The clinical facilitators need to develop social-emotional skills for their own and their students' emotional well-being.

5.2.3 Preparation as clinical facilitator

Novice clinical facilitators need preparation for their role as clinical facilitator and this should to be backed up by formal education. The participants felt that they needed to learn certain skills and to acquire knowledge about how to teach students so that they would be able to teach students holistically. They believed that they would be better equipped to offer their students emotional support when this was necessary.

In the absence of mentoring, the novice clinical facilitators had to fall back on what they themselves had been taught by their educators. The participants indicated that they then employed different teaching methods and used a trial-and-error approach in an attempt to meet their students' needs. The trial-and-error method sometimes succeeds and at other time it fails, which could potentially be to the detriment of students.

Unfortunately, the trial-and-error approach featured very prominently in participants' feedback regarding their development as clinical facilitators. According to the relevant literature, the process of self-directed learning requires that the individual identify her/his own learning needs. Therefore, it is to be expected that a clinical facilitator will experience some areas of trial and error (experiential learning) but they should have access to a mentor for guidance.

It is important that a mentor be available to offer guidance to a novice clinical facilitator. However, if the clinical facilitator lacks self-directedness, she/he will be unable to either identify or address her/his learning needs. The mentee is responsible for her/his own growth and for identifying areas that require development.

The participants indicated their responsibility to motivate the students. However, because motivation comes from within, clinical facilitators should rather focus on creating an environment that is conducive to learning and promotes self-motivation among students.

Conclusion statement: Theme 2 − Preparation as clinical facilitator

The researcher therefore concludes that, in the selection of clinical facilitators, there should be a strong emphasis on the candidate's ability to demonstrate self-directedness.

A formal nursing education qualification or other formal preparation is necessary to prepare clinical facilitators for their new role.

When students approach clinical facilitators for support in respect of their (the students') personal problems, the clinical facilitators should make use of the available referral system to assist these students to obtain professional help.

5.2.4 Role clarification

There is a sense of responsibility amongst clinical facilitators to fulfil their various roles in the hospital but these roles are not clearly specified.

Clinical facilitators do not form part of a specific group in the hospital which leads to feelings of isolation and a lack of support. They would rather express their need for support during the clinical forum meetings. This could also be an ideal place for clinical facilitators to identify a mentor. As the institution in which the study was conducted has only one or two clinical facilitators per hospital, a mentor might not be available on the premises to render assistance. A mentor will have to be identified for guidance and support. This might also be a good idea to instil best practices from one hospital to another.

Not being considered as managers clearly affected the sense of belonging. The hospitals often use clinical facilitators to fulfil certain tasks that are considered to be the role of a manager e.g. managing the hospital after hours. Hospital management should

therefore clearly indicate the position on the organogram and define the functions of a clinical facilitator. This is sure to alleviate feelings of exclusion and moreover support the clinical facilitator to know exactly what is expected of her/him. The literature is silent on the clinical facilitator's role as manager but the leadership for change that clinical facilitators provide did receive some mention.

The feelings regarding lack of support from management were apparent. However, as self-directed learners, facilitators themselves should try to find the solution before soliciting the support of management. Clinical facilitators must seek opportunities to create innovative learning experiences and develop a learning environment in which their students are able to thrive. As soon as management sees the value of clinical facilitators, management may decide to offer better support.

Conclusion statement: Theme 3 − Role clarification

A clear, comprehensive job description will assist the clinical facilitator in understanding her/his role and position.

Clinical facilitators need to be supported and feel part of the group and can be exposed to communities of practice like the clinical forum. This will not only allow them to identify mentors but also mitigate feelings of isolation.

5.2.5 Sense of responsibility

It was evident that the participants lacked confidence in their own abilities. They experienced conflict regarding whether they were/were not adequately equipped to fulfil the role of clinical facilitator to the optimal benefit of the student.

The participants felt responsible for the outcomes achieved by their students. Clinical facilitators should guide students to take responsibility for their own actions and for their clinical outcomes. Clinical facilitators should neither focus solely on the operational management of students nor on the day-to-day completion of tasks. Clinical facilitators should take responsibility for moving forward in the nursing career by delivering safe practitioners. They should not merely train students so that they will pass but also to deliver safe patient care to the patient as a recipient of the care of their students.

Conclusion statement: Theme 4 − Sense of responsibility

Feeling equipped for clinical facilitation will enhance the confidence of clinical facilitators. However, a lack of ability to support their students and perform according to the standards set for them, might hinder their confidence. Clinical facilitators tend to focus on the student outcomes rather than on patient care. The perception often held is that if a clinical facilitator is able to act with confidence she would feel that the student outcomes reflect her abilities. This in itself should be addressed during mentoring of clinical facilitators in order to ensure a more comprehensive outcome that result in student success as well as quality care.

5.3 OUTLINE OF A MENTORING PROGRAMME FOR CLINICAL FACILITATORS

This section addresses the final objective of this study. Based on the findings in this study, the researcher drew up an outline of a mentoring programme. The proposed mentoring programme is linked to an orientation programme and comprises two phases, namely Phase 1: orientation and, Phase 2: mentoring (see Figure 5.1).

5.3.1 Phase 1: Orientation

This mentoring programme had its origins in and was inspired by a study conducted by Gilbert and Womack (2012:101), which is described in Chapter 4. The latter study indicates that a mentoring programme should be preceded by an orientation programme. Phase 1 of the mentoring programme is to consist of a weeklong orientation programme. Although one week is a short period for orientation, it should be part and parcel of a mentoring programme. This orientation is to address operational matters such as student hours, student objectives and hospital orientation. It will include the role and responsibilities of a clinical facilitator such as student accompaniment and hospital-staff training. The inclusion of social-emotional skills will provide the clinical facilitator with basic skills as she/he assumes the position of clinical facilitator. It will also focus on preparing clinical facilitators for their teaching role. Attention to teaching strategies and reflective practices will equip clinical facilitators with the necessary teaching skills. Support services will be provided (e.g. student support for the referral of students with emotional problems) so that referrals can be made.

5.3.2 Phase 2: Mentoring

The duration of Phase 2 of the mentoring programme will be one full year. A mentor will be identified for each mentee and the expected outcomes of the mentoring relationship will be discussed. The mentor will be available for a day per month. During this phase, the mentee will be encouraged to keep a reflective diary to help her/him identify learning needs. The actions to be taken by the mentee to address her/his learning needs may be discussed with the mentor or the mentor may be consulted for advice regarding the mentee's identified learning needs. This reflective practice could serve to support the mentee to develop/further develop as a self-directed learner. The second part of Phase 2 will entail a community-of-practice meeting that is to be held monthly. The clinical facilitator is strongly advised to attend the clinical forums that are held for clinical facilitators.

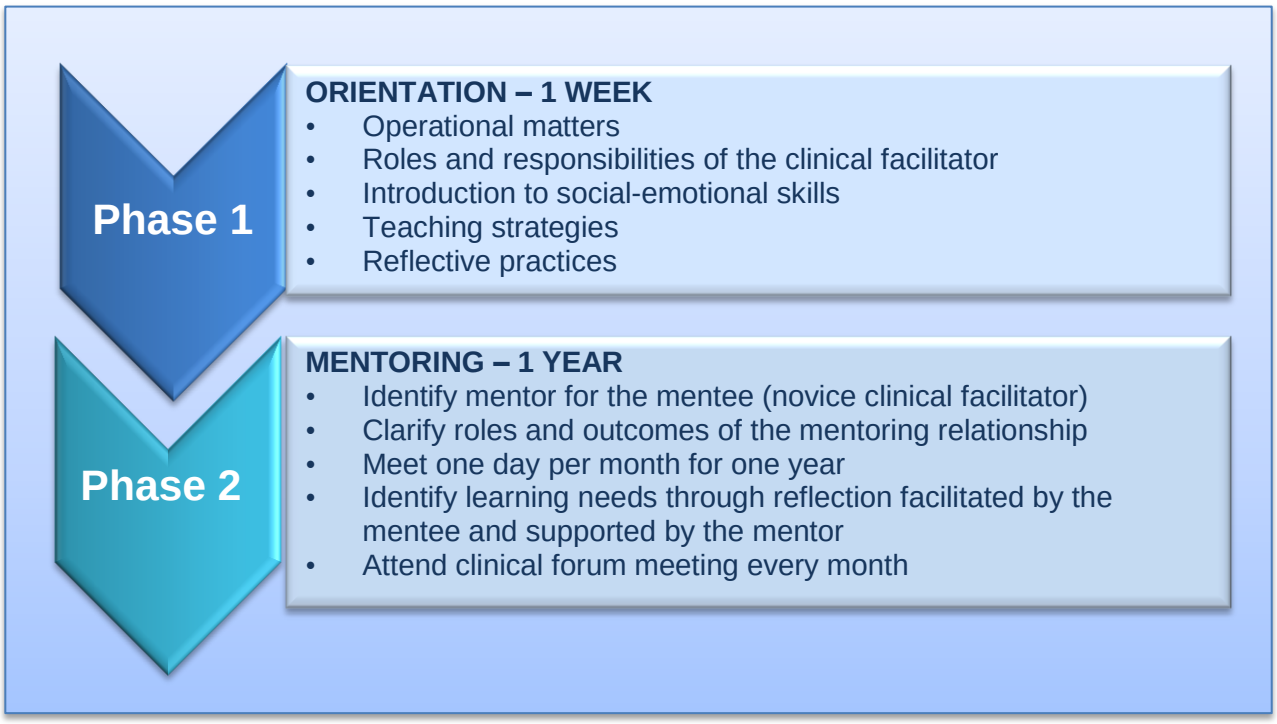

Figure 5.1: Outline of a proposed mentoring programme for novice clinical facilitators

After completion of the programme the development and progress of the mentees should be assessed. Their needs for further development could then be identified. Opportunities for monitoring progress could be identified and discussed at the clinical forum meetings as well as the plans to address these needs.

5.4 STUDY LIMITATIONS

A number of the participants knew that the researcher had previously been a clinical facilitator. During the focus groups, the participants actually referred to the assistance that had previously been given to them by the researcher during her term as nurse educator. This could potentially have influenced the discussion. However, the researcher ensured that the participants would feel free to relate their experiences. During the data-analysis process, the researcher reflected regularly to ensure that she was bracketing herself and remaining unbiased. The services of a co-coder were used to ensure that the data would be analysed objectively. Although the researcher is employed at the head office of the institution involved in this study, her position is not related to the clinical facilitation of students. The researcher was sensitive to any biases or influences related to this particular circumstance and always ensured that the discussion would remain focused on the phenomenon under investigation.

This study was conducted in the hospitals of one private hospital group, which means that the findings only apply to their specific context. The study could, however, be replicated in other settings.

5.5 RECOMMENDATIONS

Recommendations are based on the findings of the study. The researcher makes the following recommendations for practice and further research:

5.5.1 Recommendations for practice

The findings in this study have revealed that there are currently no formal mentors for the mentoring of novice clinical facilitators. It is therefore recommended that hospitals identify mentors from among peers who have experience and demonstrate expertise. A list with the names of the mentors could be made available to all the clinical facilitators and the mentees themselves could then decide who they would like to mentor them.

For a mentorship programme to be effective, it is important that mentors be adequately prepared. Therefore, it is recommended that mentors be identified and prepared for their role through mentor training.

It is recommended that a clear job description be developed, one that stipulates the roles and responsibilities of clinical facilitators. Because the roles and responsibilities are currently not clear to either the clinical facilitators or other stakeholders in the hospital environment, many roles are arbitrarily added to a clinical facilitator's existing role. This creates stress and frustration.

The focus groups revealed that, while clinical facilitators are often also required to fulfil managerial roles, management unfortunately does not seem to regard the clinical facilitator to be part of the management team. The researcher recommends that the position of the clinical facilitator be indicated on the organogram. This is sure to clarify what management expects of clinical facilitators to put an end to their discomfort in this regard.

The researcher recommends that clinical facilitators be carefully selected and that selection criteria be developed to serve as guidelines. This recommendation is supported by Haggerty, Holloway and Wilson (2012:37) who state that when clinical facilitators are carefully selected and supported, they are able to be effective in their new role. The clinical facilitator should be an experienced clinician and should also have obtained a nursing education qualification. According to the relevant literature, a clinical facilitator will benefit from having a formal nursing education qualification in that such a qualification will enable her/him to educate students in terms of an education didactic focus.

Besides having met the selection criteria, candidates should also demonstrate self-directedness in their learning. Self-directed learning will not only assist the clinical facilitator in her/his new role but, according to the literature, self-directed educators will guide their students to become self-directed learners. During the selection process of clinical facilitators, the candidates will be requested to provide a portfolio containing evidence of self-development.

5.5.2 Recommendations for nursing education

The programme leading to a nursing education qualification includes aspects related to clinical facilitation. However, a more specialised focus on clinical facilitation could be of value to clinical facilitators. It is therefore recommended that a formal clinical facilitation programme that specifically includes educational aspects related to clinical facilitation, be developed and strongly recommended to all clinical facilitators.

A student centre or a helpline should be available to render assistance to students who have personal problems. This will ensure that the clinical facilitator is able to support the student and, when required, a referral can be done. This will also help the clinical facilitator to focus on clinical facilitation and to prevent role expansion into areas not related to their responsibilities.

Recommendations on the implementation of the mentoring programme for clinical facilitators (outlined in 5.2) should be made to nursing education stakeholders. This will ensure that the implementation of the programme is done in a manner that is practical, sustainable and effective.

5.5.3 Recommendations for further research

In this study, it was concluded that the clinical facilitators' forum serves as a community of practice. It is recommended that a study be conducted to investigate the utilisation of communities of practice as platforms for the discussion of best practices. Best practices can be used as learning opportunities for clinical facilitators. The findings of this study could moreover be used to inform the utilisation of a forum for offering peer support to novice clinical facilitators.

5.6 CONCLUSION

Novice clinical facilitators have to adapt to the facilitator's role once they have been appointed to the position. To be effective educators, clinical facilitators must be prepared for their new role. The light at the end of the tunnel for all novice clinical facilitators is that, even though it is true that some educators are born with a gift to

teach, others are nevertheless also able to master this art that can be learned and developed (Spencer 2013:15).

Mentoring is an essential part of the process of moving from novice to expert. The findings of this study have revealed that novice clinical facilitators need mentoring. Orientation is part of the mentoring process but it should precede the mentoring of a novice clinical facilitator. Mentoring should not be a once-off process – it should be done over time to enable the mentor to be available throughout the entire development process. The learning needs of clinical facilitators should be addressed in the orientation programme. Certain kinds of learning could however only happen once the clinical facilitator has been appointed and is being exposed to the demands of the position. The clinical facilitator's learning needs should then be identified through reflective practices so that she/he will be able to address the learning needs. The mentor will also be able to assist the novice clinical facilitator when the latter does not know how to address the identified needs.

When clinical facilitators identify and address their own needs they could be said to be self-directed in their learning. They should identify their own learning needs and gaps in their learning in order for them to teach students to the best of their ability. When self-directed clinical facilitators lead and effectively facilitate students, they should turn out to be well-trained clinicians. Self-directed clinical facilitators will moreover teach their students to become self-directed professionals. Self-directed nurses will identify areas in which they themselves need to develop. A well-developed nurse will be able to influence practice positively, which will naturally result in a nurse who significantly influences practice by delivering excellent nursing care.

This study set out to determine the mentoring needs of clinical facilitators and to understand them. The study provided insight into and a better understanding of the mentoring needs that could influence the decisions to include mentoring in the novice clinical facilitator's learning process. The findings of this study have informed recommendations that will enhance the mentoring process of clinical facilitators.

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ANNEXURES

ANNEXURE 1: ETHICAL CLEARANCE CERTIFICATE

UNISA university of south africa

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

HSHDC/273/2013

Date: 10 December 2013 Student No: 4854-939-8

Project Title: Mentoring needs of clinical facilitators in the private healthcare sector.

Researcher: Izelle Loots

Degree: MA in Nursing Science Code: MPCHS94

Supervisor: Prof G van Rensburg
Qualification: D Litt et Phil
Joint Supervisor: -

DECISION OF COMMITTEE

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

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE 2: INSTITUTIONAL PERMISSION FROM THE PRIVATE HOSPITAL GROUP'S RESEARCH COMMITTEE

07 April 2014

ATTENTION: Izelle Loots

APPROVAL FOR RESEARCH STUDY

TITLE: Mentoring needs of clinical facilitators in the private healthcare sector.

Our previous correspondence refers.

The Research Committee of [redacted] has granted permission for your study to be conducted within the company's facilities.

We look forward to seeing the results of your research once it is completed.

Yours sincerely

Anne Roodt
Education Specialist

[redacted]

ANNEXURE 3: LETTER TO SEEK PERMISSION FROM HOSPITAL MANAGERS

PO Box 288
Irene
0062
xxxxxx 2013

xxxxxxxxx
xxxxxxxxx
xxxxxxxxx
xxxxxxxxx
Gauteng
South Africa

Dear Madam/Sir

PERMISSION FOR RESEARCH IN A MASTER'S STUDY

I am a student at the University of South Africa and am doing this study in accordance with the requirements of a Master's degree. The study is entitled *Mentoring needs of clinical facilitators*.

The purpose of this study is to identify the mentoring needs of clinical facilitators. By exploring the mentoring needs of clinical facilitators, a mentoring programme for clinical facilitators can be developed. This could contribute to effective clinical facilitation and could improve learning in the clinical environment and consequently improve the quality of care. The research involves that the clinical facilitators working in your hospital will participate in focus groups.

Ethical principles will be adhered to in this study in that the name of the institution will not be mentioned in the report. The participants' privacy will be respected and information will remain confidential. Data that are collected will also be processed in such a way that responses can in no way be linked to a particular person. The participants will participate in the focus groups at the college before the commencement of their monthly clinical forum. The clinical facilitators will therefore not be required to spend additional time away from the patients and their students. This will therefore not intrude on patient care.

The copy of the consent granted by [redacted] ethical committee is attached. Secondly, a copy of the full research proposal is attached in which all methodological and ethical issues are explained. Should you have any further questions, you are welcome to contact me or my supervisor, Prof GH van Rensburg on 012 4296514 or at vrensgh@unisa.ac.za. The completed research report will be available upon request.

I hereby request permission to collect the data for my study from clinical facilitators working at your institution.

Yours faithfully

I Loots (Ms)

Tel no: 083 408 3103

ANNEXURE 4: PERMISSION FROM HOSPITAL MANAGERS

19 March 2015

Izelle Loots
Life College of Learning
E-mail: Izelle.Loots@lifehealthcare.co.za

Dear Izelle

RESEARCH IN A MASTER STUDY AT

We are pleased to inform you that you have approval to conduct the research.

Yours sincerely

Jayesh Parshotam
HOSPITAL MANAGER

ANNEXURE 5: INFORMED CONSENT LETTER

STUDY TITLE: MENTORING NEEDS OF CLINICAL FACILITATORS

RESEARCHER:	**IZELLE LOOTS**
SUPERVISOR:	**PROF GISELA VAN RENSBURG**

You are invited to participate in a study on the mentoring needs of clinical facilitators.

Based on your position as a clinical facilitator, you could provide information about the mentoring needs of clinical facilitators. The researcher wants to understand what you regard to be the mentoring needs of clinical facilitators in respect of performing their daily duties. The aim of this study is to explore the mentoring needs of clinical facilitators and to develop a mentoring programme for clinical facilitators.

The researcher believes that this study will contribute to the body of knowledge with regard to the mentoring that a clinical facilitator needs in order to be an effective clinical facilitator. The significance of this study lies in the effective clinical facilitation that could result from a mentoring process and the improvement of the quality of care that could result from it.

Your privacy will be respected at all times and information will be kept confidential. Data that are collected will also be processed in such a way that responses can in no way be linked to a particular person. You are requested to participate in a focus-group interview at the college before the commencement of the monthly clinical forum. No time will therefore be used that could be to the detriment of the institution, its patients or the students and your participation will therefore not intrude on patient care.

Your participation is entirely voluntary and you may at any given time and without penalisation withdraw from the study.

Should you agree to participate, you are requested to read and sign the section below. You are also free to contact my supervisor, Prof GH van Rensburg on 012 429 6514 or at vrensgh@unisa.ac.za should you have any questions or concerns.

CONSENT:

I participate in this study voluntarily. I may also discontinue my participation in the study at any time without having to provide a reason or without any form of penalisation whatsoever. I have been assured that my identity will at no time be revealed. I am aware of and consent to the audio recording of the discussions. I was assured that all data will be kept in a safe place to which only the researcher has access.

I understand that identifying my needs could cause me some anxiety due to the disclosure of work-related information. I realise that the study will take approximately two hours of my time and will involve a focus-group interview.

If I have any questions regarding this study, I may contact the researcher, Ms Izelle Loots:

Email address: izelle.loots@lifehealthcare.co.za

Cell number: 083 408 3103

_____

Participant's signature Date

_____

Participant's signature Date

ANNEXURE 6: DEMOGRAPHIC DATA QUESTIONNAIRE

Dear Participant

Kindly supply the following demographic data.

The supplied demographic data will assist the researcher in the data-analysis process.

Thank you for your time.

Male/Female	

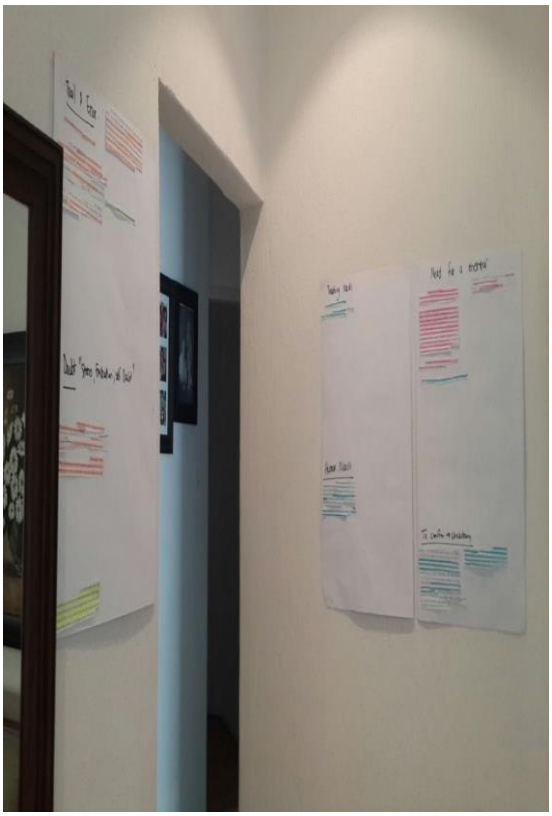
Age	

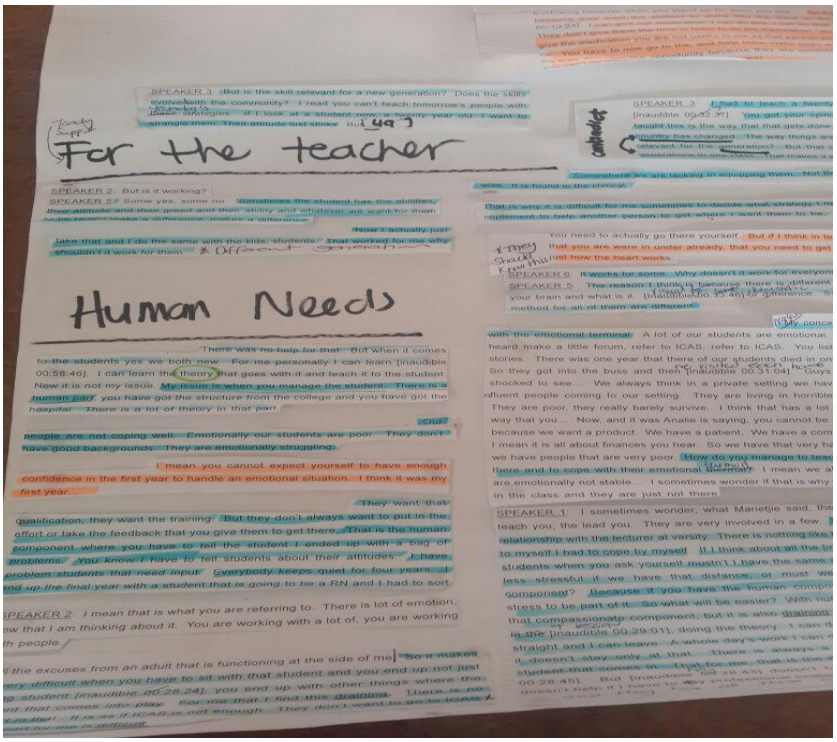
Qualifications	

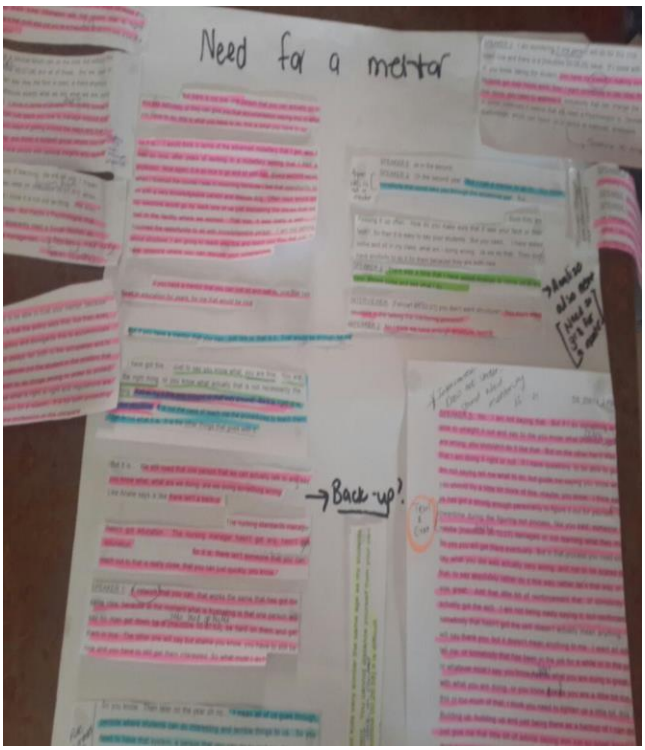
Special courses completed in clinical facilitation	

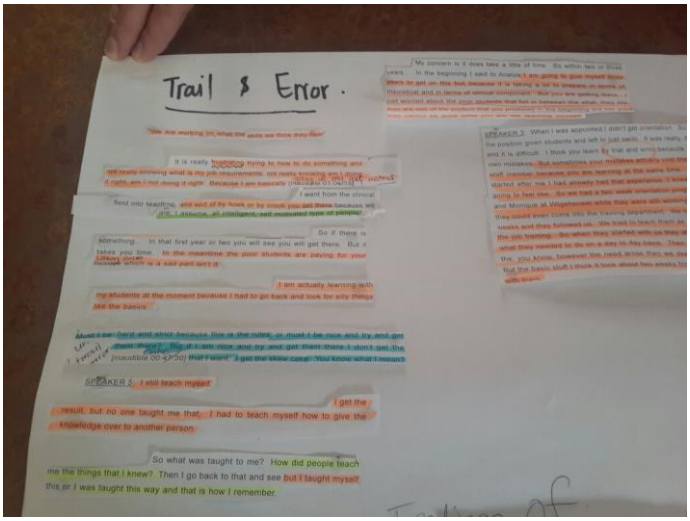
Experience of working as a clinical facilitator	Years		Months	

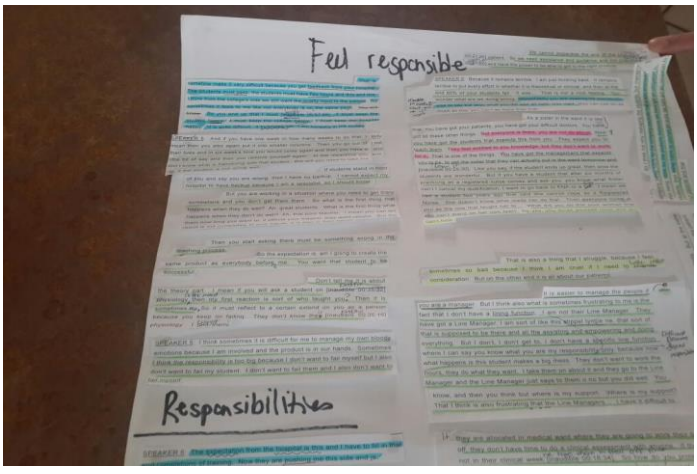
ANNEXURE 7: INTERVIEW SCHEDULE, SAMPLE OF ONE DATA ANALYSIS AND DATA ANALYSIS






Need for a mentor
Back-up!


Trail & Error.


Feel responsible
Responsibilities

INTERVIEWER: Okay. Good afternoon on 27 March 2015. I would like to welcome each and everybody here at today's focus group. Thank you that you have filled in the consent forms. I would like to tell you that this group is going to be an hour, maximum an hour and half. I understand it is Friday and it is Friday for you too, so we would like to keep it to the time ranges that we have for a focus group. Can we settle some of the rules within the group just for today? We know, and I have given you the consent form and I have explained to you that the consent is that you are giving voluntary consent and that I will keep this confidential as much as possible. But we are six people sitting here today. I would like to ask that I will keep everything confidential as we will respect each other and each other's opinions today and will, that everything that is said will stay in the group. Can we please consent if you want to?

SPEAKERS: Yes.

INTERVIEWER: Okay, thank you. The other rule that I would like to put forward is that we please put our phones on silent. This will help us to keep our thoughts focused because if there is a telephone that is going off and it is your turn to talk then sometimes it just disturbs and disrupt the process. Then I would like us to ask that people give each other all an opportunity, because you are five people that is in the ideal position to come and tell us what, everything about the topic that I am going to discuss today. So I would really like all of your inputs. I want to ask that we will give each other all an opportunity to participate in this group today. I would like us to go around the table; this will help with transcribing but also to introduce ourselves to the study. I will start with myself. I am Izelle Loots and I am a Nurse Educator here at Life Health Care College.

SPEAKER 1: [Annemarie Hatdat? 01:11:15] Clinical Training Specialist at Wilgers Hospital.

INTERVIEWER: Just say what is your name again?

SPEAKER 1: Annemarie Hatdat.

SPEAKER 2: [Adelle Geldenhuys? 01:11:07] Clinical Training Specialist at Wilgers.

SPEAKER 3: [Tanya Opperman? 01:11:02] Clinical Training Specialist by [Peglaray? 01:11:00] Rustenbrug.

SPEAKER 4: [Frizelle Shay? 01:10:57] Clinical Training Specialist at Wilgers Hospital, ag Eugene Marais.

SPEAKER 5: [Essel De Wet? 01:10:51] Clinical Training Specialist Eugene Marais theatre.

INTERVIEWER: Okay. Now I would like to introduce the study to you so that you can understand what this group is all about. When we are in the hospital people look at a very good sister in the ward and they say this person we must appoint her as a Clinical Facilitator, or in theatre we have to appoint that lady as a Clinical Facilitator because she is a good Clinician. Does that make her a good educator? Sometimes there is mentoring needs that we need to be able to do our job better, or to be able to do our jobs. Many times we are orientated within the hospital that here is the key, this is the file. But are we really mentored to do our job, to be able to take the student from point A to point B? Or is it something that we pick along, up along the line? Today I want to ask from you, what is this mentoring needs that you need or that a new [novas? 01:09:33] Clinical Facilitator need when I am being appointed into the position as a Clinical Facilitator? Is there anyone that would like to start? Remember right and wrong, it doesn't matter. Whatever your input is, is perfect.

SPEAKER 2: I think in my opinion if you say somebody is clinical good in wherever she is working at the moment and she is appointed a CTS it is not a guarantee that that person will be successful as a trainer because there is certain skills that you definitely need to get things into other people's head or let other people understand what you are trying to teach them. It is not something that everybody is born with to teach, to teach people. You need to know to go to the level of the person that you are teaching. Like I said it was an eye opener for me with the first Pen1 that I am having at the moment. I never realised what the level of, how low the level of competence was. I had to go down with how I am teaching my Pen1 compared to the BC's that I always had. So there is a lot of things that I do need, think that we need to take... It is not that if you are a good practitioner I think that you will, you can just assume that that person will be a good teacher as well of that good clinical skills that she has. I don't know how you guys feel, whether it just comes automatically? It didn't come for me. I had to work hard to...

SPEAKER 4: I also [inaudible 01:07:41] when I was appointed in the position that I am in now. I also realised that you actually need people skills as well to be able to teach because I came from a ICU background and then I was appointed in this position with nothing, no backup, no information as such. Listen this is now what you are going to do they said to me. Frizelle, you are so good in what you are doing and we need you to please come and help us train. Then I realised but I need some sort of skill to be able because it is not everybody that has got, that is a good judge of character in the sense of I need to be able to know how to communicate with a person with a short temper. How do I communicate with a, with a person that is, that has attention deficit? I didn't know how to do that. I had to maar work out my way as I went about on, on how will I now get this girl's attention. She has got a problem with this, she can't focus for long. Now what now? In the clinical field we usually do on the spot training and if she doesn't focus that to me was a problem because I have got just this time to teach you. We are busy, we are task orientated and now I quickly need to teach you this. So if you are not focused you will lose out. That to me was a big frustration. So yes I really think what other than sorry academic acknowledge, you also need people skills to be able to do that.

SPEAKER 2: I have been working eighteen years in maternity, form college straight into maternity for eighteen years. So and then I went and did my education. Now the education they taught you in the university and what you actually need to do in practical is totally two different stuff. You know you, you cannot... Ah a compliment and you have your cycles and all those things but the theory and the practical doesn't come together. So mentoring, I really need mentoring in so many levels. Not only to, not handle, but to work with the students, but everything that is going around with the administration parts, the knowhow, everything.

SPEAKER 3: You need that how to plan a lot of students. Izelle helped me how to plan when you have got a lot of students and you only have got one person. How do you handle that? If it wasn't for her I... If I was...

SPEAKER 2: If I was left alone and so here is your Pen1 students, go ahead, I wouldn't know where to start, what to do, what to do with them, what I must teach them, what I must do in the clinical field. So ja I have a mentor and she is great and she is helping me, you know adjusting, taking the Pen1's and what

I need to know. My fear is, I try not to think about it, is issues not doing next year and I need to take this group to a second level. Will I be able to? Because you don't want to harm them you know. You really want to, to build them in make them good nurses. That is why we are all here. So I don't want to do something that is not right or going to harm them in any certain way. So that is why mentorship... Because on paper it doesn't exist. It doesn't really exist on paper. There is a lot of books about education on how to present the class and, what do you call it, Powerpoint and doing a paper and all those things. But really working with the students, you know, ja that is what...

INTERVIEWER: If you say she is a great mentor...

SPEAKER 2: Ja.

INTERVIEWER: ...what makes her a great mentor?

SPEAKER 2: You, she is approachable in the first place. You can go to her and you can ask her any question and she doesn't make you feel stupid by asking the question. Although you are in nursing for more than twenty years now and you are asking this question, she doesn't let you feel stupid about it, and the fact that she is knowledgeable. She is a person with so much knowledge. I am scared I am going to lose her because I can take so much from her and I can learn so much from her. The way she is handling the students you know. She is very strict but she is also a mother you know. She has it both sides. For me she is a... You know when you were in college you had that person that you looked up towards. You know, I want to be like her. She is almost that person.

SPEAKER 1: Now I want to agree with all the three ladies before me also being a person that was thrown into the deep end with the orientation of two days and then I had a two different groups, three different groups that was on my lap that it was overwhelming, very, very stressful. But being part of my character I was just so I sat down and I said okay let me figure this out. So then I finally knew this and that and this is blocks and that is assignments and this is summates. I didn't even know what the word summative and formative mean, but finally I got that under the knee. What was nice and very awarding for myself being in this deep end and just coming up for some oxygen every now and then was to see that students enjoyed the way I approached them. I am also feeling very strong that we need that people skills and I think some

people have more of them naturally than others. But it is always a bonus if you can get more skills regarding that aspect of handling with people because you work with different personalities, different levels of emotional inelegance and maturity. That is always... It is not only the students, it is also the staff that works in the different units and their Unit Managers. So that they don't feel threatened by your, your presence there in the unit, and also the staff that, that, that you approach and you... Maybe students they are doing something the wrong way, to know how to handle that and to know oh here is some action coming and how to, to already see it and how to handle it. So that will be very awarding if, if, if one can get those, that support, or like I said more, you know get training on that. Then personally for myself I feel very strong that every CTS needs to have the assessor course done by an outside company that is... Well if Life have it in their work skills program it will be wonderful. But that you know that you go on a course for five days, you work out different programs that they expect from you to do so that you know this is the way I asses people. This is what I must look out for because now we have a great mentor that we can use. But if you really went through that course and you know this is what I am looking for, this is what I am looking for, yes I agree with her. This is... I think it just gives you that boost that you know, you know what I know this is... It is like that matric certificate that you have you know. I have done matric on my own. That is how I feel. I really have a need to know that an assessor course. Again then, you get the different objects, objectives and goals that you need and we all hanging in the same direction in the end for the benefit of our students and to see that we have quality personnel and staff in the end wherever they are going.

INTERVIEWER: Okay.

SPEAKER 5: I am in theatre now for twenty years and the past eight years I do the training and there was no one to guide and take the way and tell me this must be done and this is how we get the standards. I saw that everybody was going on, on its own way. The college has got a way that they measure and that they evaluate the students and the university has got their way. So there is different methods. Then the ODA's come and it was, they were also being evaluated and cared for differently. But it is also very difficult because you have to guide your staff members and the students. So I am actually very busy.