A STUDENT SUPPORT PLAN FOR CLINICAL PLACEMENT OF NURSING STUDENTS IN RWANDA

by

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DECLARATION

I declare that **A STUDENT SUPPORT PLAN FOR CLINICAL PLACEMENT OF NURSING STUDENTS IN RWANDA** 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.

I further declare that I submitted the thesis to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

24 January 2022

SIGNATURE **DATE**

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ABSTRACT

The quality of support that students receive during clinical placement depends on planning of clinical placement that integrates students' needs with available support services, materials, and resources. A qualitative study was conducted with the purpose of proposing a student support plan for clinical placement of students to enhance clinical learning according to the affective, cognitive, and systemic dimensions of student support. Data was collected by means of five focus group interviews with nursing students registered for the bachelor's (undergraduate) degree programme leading to registration as a nurse, at a selected university in Rwanda.

The two major themes that emerged were, firstly, support needed from nursing students' clinical learning experiences and, secondly, suggestions to enhance clinical learning during clinical placement. From the students' feedback, it was evident that nursing education institutions need to collaborate with the healthcare institution to address students' support needs, which could enhance clinical learning.

As an outcome of the study, a student support plan for clinical placement of students was drawn up, which can be used as a guide when planning for students' clinical placement, and which could support students in practice. Further research is recommended to explore student support needs according to level of study in the bachelor's nursing degree programme, which could provide insights that can be used by future researchers to devise a framework for a student support plan for clinical placement of nursing students.

Key concepts

Clinical facilitation; clinical learning; clinical learning experiences; clinical supervision; clinical training; student; nursing student; students' support needs; support; Tait's framework of student support.

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DEDICATION

I dedicate this study to my grandfather, Mr Donatus Ndifon who has been a great pillar of support during my "ups and downs" in life.

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LIST OF ABBREVIATIONS

CLE	Clinical learning environment
PPE	Personal protective equipment
NCNM	National Council of Nurses and Midwives
A0	Nurse trained at the bachelor's degree level
A1	Nurse trained at the advanced diploma level
A2	Nurse trained below the advanced diploma level
DH	District hospital

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Nursing education consists of theoretical and practical training of nurses, where the primary purpose is to prepare them for their duties as providers of nursing care to patients. According to Yildirim and Dalcali (2020:2055), both theory and clinical practice are compulsory components of nursing education. Thus, it is in line with the educational philosophy of pragmatism, where it is believed that human beings learn through a "hands-on approach" (Dewey 1938). Arkan, Ordin and Yılmaz (2018:127) state that clinical education is the cornerstone of nursing education, as it ensures that students gain knowledge and skills that are related to direct patient care.

Globally, clinical training is an essential component of basic nursing programmes (McAvoy & Waite 2019:18). Clinical training is defined as teaching and learning aimed at reaching professional competence (Bruce & Klopper 2017:316). Competent professional nurses are nurses that have basically fulfilled their nursing responsibilities (Fukada 2018:7). During clinical training, nursing students learn to apply the theory of nursing to real patients in the real world, that is, they learn to practise the art and science of nursing (Xaba 2014:1). In Rwanda, the National Council of Nurses and Midwives (NCNM) identifies clinical practice as one of the major requirements for licensing, as it makes up 60% of the licensing examination. In this regard, clinical practice in the curriculum of the bachelor's general nursing degree programme constitutes 235 of the total 490 credits, and it is a prerequisite for graduation. To meet the ever-changing and diverse needs of the entire nursing student population, it is essential to identify nursing students' educational, personal, and administrative needs during clinical placement, as this can assist stakeholders to provide students with support, so that they can succeed cognitively, affectively, and career-wise. However, student support needs during clinical placement in Rwanda are as yet unknown.

Effective clinical facilitation is essential during clinical training (Andrews & Ford 2013:413), to ensure the quality and the success of nursing students' clinical learning

(Lekalakala-Mokgele & Caka 2015:8). Clinical facilitation refers to the assistance and support given by all nurse educators, professional nurses, and clinical preceptors to undergraduate nursing students during clinical placement (Muthathi, Thurling & Armstrong 2017:2). Clinical learning not only enables nursing students to learn to apply the theory of nursing in real patient care in the real world; it also enables them to gain the knowledge, skills, and attitudes required to become competent professional nurses, for the provision of quality health services (Liljedahl, Boman, Fält & Laksov 2015:766). Clinical learning happens mostly in the clinical learning environment, where nursing students gain experience caring for patients (Tiwaken, Caranto & David 2015:66). Quality clinical learning experience can positively influence students' achievement of their clinical learning outcomes (Habimana, Tuyizere & Uwajeneza 2016:1; Preethy, Erna & Mariamma 2014:209), and it can establish quality healthcare (Lovecchio, DiMattio & Hudacek 2015:254).

The role of clinical facilitators is described as facilitating integration of theory with practice, monitoring students' progress, identifying and supporting learning challenges, providing student support, supervision, and assessment in the clinical setting (Muthathi et al 2017:2; Xaba 2014:2). Globally, the term for clinical facilitators varies according to country and context. Due to this global variation, the terms "preceptor", "mentor", "clinical facilitator", "clinical instructor", and "educator" are used interchangeably in the literature. In the context of Rwanda, mentors are qualified and experienced nurses working at healthcare facilities who also have the responsibility of facilitating and supporting teaching and learning in the clinical setting, while educators are qualified individuals from the university who are tasked with facilitating students' clinical training for the achievement of learning outcomes, as well as with teaching theory at the university. It is the joint responsibility of mentors and educators in Rwanda to facilitate students' learning in clinical settings.

Several models of clinical facilitation have been identified in the literature for supporting the clinical training of nursing students. The preceptor-facilitator model is described as a helpful model, as it offers an excellent clinical supervision framework to support nursing students' clinical learning, while fostering a positive clinical learning environment (Franklin, Leathwick & Phillips 2014:134). Franklin (2013:39) asserts that both the preceptor-facilitator model and the dedicated education unit model are helpful supervision models to support students' clinical learning, and that they provide the best support in the clinical learning environment. Franklin (2013:39) argues that the dedicated education unit

model is the preferred model, as it supports students in the clinical environment, by fostering critical thinking through reflective practice, and that it provides greater learning opportunities and benefits for all stakeholders involved in clinical training of nursing students.

Availability of educators in the clinical setting is viewed as being beneficial for creating a clinical environment that can help students achieve their clinical learning objectives (Muthathi et al 2017:6). Furthermore, nursing students perceive educators' active involvement in clinical teaching as a form of support for their clinical learning, due to consistency in performing procedures when transferring skills from the skills laboratory to the practicum (Muthathi et al 2017:6). However, Rajeswaran (2016:4) argues that educators often take more of an assessment role than providing support to students during clinical practice. Sweet and Broadbent (2017:30) support this view, by pointing out that educators' other responsibilities of research and teaching at the university, and the wide range of placement settings for nursing students, which require frequent travelling, often result in a significant reduction in time spent on clinical facilitation of nursing students' clinical learning.

Mentors (in Rwanda the term "mentors" refers to clinical site nurses that provide support to students and direct care to patients in the clinical environment) are described as a major influence for students in the clinical learning environment. The influence of mentors relates to fostering the development of critical thinking and establishing a strong nursing identity among nursing students (Rajeswaran 2016:5). However, Franklin et al (2014:136) highlight concerns about mentors' ability to effectively facilitate students' clinical learning, as they are faced with an increased workload, they lack formal educational training on clinical facilitation, and they have to perform both formative and summative assessments. The same authors suggest recruiting clinical facilitators (in Rwanda the term "clinical facilitator" refers to a healthcare provider at the clinical site whose responsibility it is to organise students during clinical placement) from within the healthcare facility where students are placed for clinical placement, as a means of providing maximum support to nursing students, due to clinical facilitators' familiarity with the clinical environment and their ability to understand students' clinical learning objectives (Franklin et al 2014:140).

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Currently there are four categories of nurses being trained in Rwanda: advanced diploma (A1), bachelor's degree (A0), master's level in eight tracts, and PhD by research. According to the Rwandan National Council of Nurses and Midwives (NCNM), the minimum requirement for registration as a nurse in Rwanda is A1. An A1, or registered, nurse holds an advanced diploma, has completed three years of post-secondary education, and has up-to-date clinical skills and a licence to practise without supervision from another nurse (Harerimana, Mtshali, Mukamana, Kimonyo, Kayihura & Mugarura 2015:7). Unregistered nurses (A2, or enrolled, nurses) are gradually being phased out since 2006 (Harerimana et al 2015:7), but they still make up a large proportion of the nursing workforce (Gitembagara, Relf & Pyburn 2015:27). An enrolled nurse is trained up to secondary level and has basic nursing training. The College of Medicine and Health Sciences of the selected university is multi-campus. The campuses are in the following three provinces, with an average distance of 124.9 km between campuses: Kigali (Remera Campus), Eastern Province (Rwamagana Campus), and Southern Province (Huye Campus). Students are placed for clinical practice in health facilities (referral hospitals, district hospitals, and health centres) all over the country. The bachelor's general nursing degree programme is a minimum four-year (eight-semester) undergraduate programme with a full-time progressive course of study. Upon completion, graduates are awarded a Bachelor of Science with Honours in Nursing degree. The curriculum for this programme is organised in modular format and consists of 490 credits, where each credit corresponds to ten hours of learning time.

The clinical training model used in Rwanda is one in which educators from the university are assigned a group of students from different levels, who are allocated to different health facilities all over the country and placed across several districts. Educators are required to travel for facilitation of individual students' clinical training. At the clinical facility level, a group of students are then partnered daily with a mentor from the health facility, who facilitates the students' learning on a shift basis. The importance of student support as an integral part of students' clinical learning has not received much attention. A shift in the curriculum from a content-driven to a competency-based curriculum (Harerimana & De Beer 2013:29) has driven a growing need for including the perspective of students in educational content and institutional policies. The university has established clinical training guidelines, which set minimum standards to achieve good practice in the clinical

training of students, to ensure competence in the clinical environment. However, these guidelines focus on the responsibilities of stakeholders involved in clinical training, and Muthathi et al (2017:2) highlight the dissonance in the roles of these stakeholders, which allows for shifting of these responsibilities and often results in a significant decrease in the quality of clinical facilitation.

The quality of nursing students' experiences may depend on the quality of the support they receive in the clinical environment (Papastavrou, Dimitriadou, Tsangari & Andreou 2016:44; Preethy et al 2014:208). From the perspective of nursing students, support means receiving help to develop to become a competent nurse (Joolaee, Farahani, Amiri & Varaei 2016:5). Froneman, Du Plessis and Koen's (2016) study conducted at a private nursing education institution in South Africa found that students could overcome some challenges experienced in practice provided they had sufficient support.

According to Tait (2000:3), students can best be supported when their support needs in terms of cognitive, affective, and systemic needs are known. Although Tait's (2000:3) student support framework focuses on students in an open distance learning environment, the primary functions of student support, namely cognitive support, affective support, and systemic support, can be applied in the clinical setting. Cognitive support entails addressing the learning materials, and in this instance, it would refer to the theory provided in class, while the affective dimension of student support refers to the creation of an environment that will facilitate commitment and self-esteem, which can address either theory or practice. The systemic dimension relates to administrative support that is effective and student-friendly, which can apply to the organisational aspect of student placement. It is crucial to explore, from the perspective of nursing students, what they require in terms of cognitive, affective, and systemic needs to be adequately supported in the clinical environment. These three dimensions of student support relate to facilitating learning, emotional/psychological well-being, and organisational aspects of placement that meet the needs of diverse students.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Overall, the quality of education of nurses depends heavily on the quality of clinical teaching and learning (Lekalakala-Mokgele & Caka 2015:9), which can be achieved through effective clinical facilitation and support (McAvoy & Waite 2019:20). Serçekus

and Baskale (2016:134) recommend more support to students in the clinical setting, as it affects student learning. In the Rwandan context, nursing students are placed in distant health facilities, which have challenges of poor accessibility and capacity constraints in terms of staffing and materials, which make these environments not conducive for students to learn optimally. Xaba (2014:105-106) highlighted some of these challenges, such as the far distance of placement facilities, while Thuss, Babenko-Mould, Andrusyszyn and Laschinger (2016:136-137) identified the challenges that professional nurses (mentors) in Rwanda experience, such as communication problems, a poor relationship between students and staff, and inadequate training of mentors. Nurse educators in Rwanda are challenged with large numbers of students and an increased workload (Harerimana & De Beer 2013:39). Despite there being training guidelines that prescribe certain aspects of the clinical training of students, they do not attend to all the clinical training needs of the students registered for the Bachelor of General Nursing degree programme in the clinical setting in Rwanda. Anecdotally, students have complained about insufficient facilitation due to educators' absenteeism, inadequate materials, such as gloves, logbooks, and clinical portfolios, inadequate support from mentors, and not meeting their learning objectives in the set time. Mentors feel that their focus is patients, not students, while educators rely on the support of mentors to students. Students have consequently found themselves in an unsupportive learning environment, where they struggle to achieve their learning outcomes. An adequate plan of support for students' clinical learning is essential, as lack of such a plan could lead to unpreparedness to meet the challenges of the clinical field (Kalyani, Jamshidi, Molazem, Torabizadeh & Sharif 2018:7). Institutional planning of student support is vital to the quality of support that students receive. Since Harerimana and De Beer (2013:29) studied the perspective of educators, and Kagabo (2017:38) studied the perspective of mentors, in Rwanda, the following question is asked to obtain the perspective of students: *"How can student nurses registered for the Bachelor of General Nursing degree programme at a university in Rwanda be supported such that their clinical learning will be enhanced?"* Answering this question will help the researcher to propose a support plan for clinical facilitation that could enhance students' clinical learning.

1.4 PURPOSE AND OBJECTIVES OF THE STUDY

In any study it is important to formulate a purpose statement to keep the researcher focused and motivated towards reaching the objectives of the study.

1.4.1 Purpose of the study

According to Brink, Van der Walt and Van Rensburg (2018:50), the research purpose is a single sentence that captures the entity of the study, while outlining the study population and the research setting. It is what the researcher intends to use to address the research problem (Creswell 2012:83). It is generated from the research problem and the research question (Brink et al 2018:50).

The purpose of this study was to propose a student support plan for clinical facilitation to enhance the clinical learning of nursing students registered for an undergraduate nursing programme at a selected university in the Republic of Rwanda.

1.4.2 Study objectives

Research objectives are concrete, measurable ends towards which research is directed, and they are articulated in the present tense (Brink et al 2018:74).

The research objectives for this study were the following:

- To explore and describe the clinical learning experiences of nursing students during clinical placement
- To describe the support needs for clinical learning according to the cognitive, affective, and systemic dimensions of student support
- To draw up a support plan for clinical placement of students

1.5 RESEARCH QUESTIONS

According to Creswell (2012:83), a research question breaks down the purpose of the study into specific questions that the researcher intends to address in the study.

The research questions for this study were the following:

- What are the clinical learning experiences of nursing students?
- What is needed to support the clinical facilitation of nursing students?
- What should a support plan for clinical placement of students contain?

1.6 SIGNIFICANCE OF THE STUDY

The study may provide valuable information regarding student support while nursing students are placed in the clinical field in the Rwandan context. This could lead to the adoption of a support plan for clinical placement, which could enhance students' clinical learning to prepare them to become competent nurses for the provision of the best possible care to patients, which may ultimately improve the quality of health services. Additionally, the proposed student support plan for clinical training, if adopted, may enhance student nurses' clinical learning, and it will probably make a positive impact on students' learning experiences, which, in turn, may facilitate the provision of safe, effective, and efficient health services to the community and the broader society, thus improving quality of life and reducing the cost of healthcare. The evidence will also form a working base, which may be transferred from one context to another by future researchers answering similar research questions, depending on the degree of similarity between the contexts.

1.7 DEFINITION OF KEY TERMS

To clarify the meanings of concepts according to the context of this study, the key concepts used in the study are defined. Creswell and Creswell (2018:79) state that it is necessary for inquirers to define terms when there is a likelihood that consumers of the research will not understand the meanings of the terms used.

1.7.1 Clinical facilitation

Clinical facilitation refers to the assistance and support given by all nurse educators, professional nurses, and clinical preceptors to undergraduate nursing students in the clinical practicum (Muthathi et al 2017:2). In this context, clinical facilitation refers to the support that is provided to nursing students by the educators, mentors, university management, and health facility management that is based on students' needs in terms of cognitive, affective, and systemic needs, to enhance clinical learning.

1.7.2 Clinical learning

Clinical learning, according to Donley and Norman (2018:36) is the process whereby nursing students are mentored, motivated, and offered opportunities to share learning to acquire knowledge, skills, and values in the clinical environment. In this study, clinical learning will refer to the process of assisting nursing students to gain knowledge, skills, and attitudes in the clinical learning environment (CLE) required to prepare them for providing safe care to patients.

1.7.3 Clinical learning experiences

According to De Swardt (2012:9), clinical learning experiences refer to the learning experiences that will occur while student nurses are placed in a clinical environment where they actively take part in caring for patients. In the context of this study, the concept will refer to all planned and unplanned events that students experienced during their placement in the clinical environment with the primary objective of acquiring learning that relates to care of patients.

1.7.4 Clinical training

Clinical training refers to teaching and learning aimed at reaching professional competence (Bruce & Klopper 2017:316). According to the clinical training guidelines of the School of Nursing and Midwifery, university of Rwanda, clinical trainers and supervisors from the nursing school and mentors from clinical practice sites have an obligation to provide regular clinical training and supervision for students, to promote learning and to safeguard the public from incompetent health workers. Clinical training is regular instruction and supervision provided by educators and mentors to students to promote learning and patient safety while students are providing direct patient care in health facilities where they are placed for clinical practice.

1.7.5 Support

Support means to provide what is needed by someone or something (*Learner's Dictionary* 2019, sv "support"). According to Joolaee et al (2016:5), support means receiving help to develop to become a competent nurse. In the context of this study, support means

providing the assistance that nursing students require in their clinical placement to become competent graduates, based on their cognitive, affective, and systemic needs. The student support plan which will be drawn up will be a detailed proposal to provide student support in clinical placement that is focused on student needs of the Bachelor of General Nursing degree programme in terms of students' cognitive, affective, and systemic needs.

1.7.6 Student

A student denotes someone who is studying to enter a particular profession (*Oxford Learner's Dictionaries* 2018, sv "student"). In this study, the term "student" will refer to any individual registered for a four-year undergraduate nursing programme at a selected university in Rwanda. On completion of this programme, the student will be registered as a nurse (A0) if they comply with the Rules and Regulations on Nurses and Midwifery Licensing Examinations № 3 of 19/04/2018 (NCNM 2008).

1.8 FOUNDATION OF THE STUDY

The foundation of the study was necessary to help the researcher establish assumptions underlying her philosophical views about what the nature of reality is.

1.8.1 Metatheoretical assumptions

A paradigm serves as a "lens", or organised principles, through which a researcher approaches and interprets reality (Brink et al 2018:20). It represents values, judgements, perspectives, standards, frames of reference, theories, ideologies, and myths adopted by researchers that govern their actions and thinking (Hegde 2015:129). According to Polit and Beck (2017:30), it is a general perspective on the complexities of the real world. Researchers can bring to their inquiry one of four world views, namely the post-positivist paradigm, the constructivist paradigm, the pragmatist paradigm, or the transformative paradigm (Creswell 2014:37).

The constructivist paradigm aims to explore, describe, and understand the context of naturally occurring events (Davies & Fisher 2018:23). The search to explore, describe, and understand student nurses' individual understandings of the world they live and work

in, and the subjective meanings of their experiences, which the researcher recognises as varied and multiple, guided her to adopt the philosophical ideas of a constructivist. Student nurses' experiences regarding the support they need in the clinical environment in terms of their cognitive, affective, and systemic needs are subjective, and individual students may have different understandings of their experiences, and they may therefore give varied and multiple meanings to these experiences. In looking for the complexity of student nurses' views, the researcher relied as much as possible on the student nurses' perceptions of their knowledge, values, and beliefs about the support they need in the clinical environment.

The researcher aimed to understand the context of the participants' environment. The context in this study was the clinical environment where students care for patients. She visited the context, but due to a lack of quiet and spacious venues to conduct the focus group interviews in the clinical settings, she personally collected data from participants at one of the three campuses of the selected university in Rwanda.

A paradigm is a researcher's set of assumptions about what reality is, how knowledge is created, and what is valuable to learn (Davies & Fisher 2018:21). This study is founded on the following constructivist paradigm assumptions.

1.8.1.1 Ontology

Ontology refers to beliefs about the fundamental nature of social reality (Hammond & Wellington 2013:144). It seeks to find out what the nature of reality is (Polit & Beck 2017:14). The multiple realities of individuals were central to the exploration, description, and meaning-making in this study. The knowledge uncovered was contextual, with the researcher being respectful of the participants' varied views about their experiences and feelings, and the meaning they make of them. The subjective truths that emerged from the interaction between the researcher and the participants were known through the participants' description of their clinical learning experiences. It was assumed that students' perceptions of the support they need in the clinical environment were subjective and individually constructed.

1.8.1.2 Epistemology

Epistemology seeks to determine the relationship between the inquirer and the phenomenon being studied (Polit & Beck 2017:14). It refers to the researcher's beliefs about how knowledge and understanding of the world is arrived at (Hammond & Wellington 2013:57). The researcher took the stance that knowledge is gained through collaborative social participation. Researching the clinical learning experiences of student nurses called for direct involvement, collaboration, and close interaction in a natural environment between the researcher and the participants, who have experienced learning in the clinical setting. Knowledge was constructed from the relationship during the research process, where participants reflected on and stated their experiences and feelings in the interaction process.

1.8.1.3 Methodology

Methodology refers to the method of knowing about the reality that is being studied (Guba 1990, as cited in Brink et al 2018:19). According to Polit and Beck (2017:19), it responds to the basic philosophical question of how the inquirer should obtain knowledge. An inductive approach was used to generate data, which was based on the researcher's ability to collect and generate data. Generalisation of the findings was done in context. Focus group interviews were used to collect data, which called for a qualitative approach in answering the research questions.

1.8.1.4 Axiology

Axiology, according to Hammond and Wellington (2013:11), is the study of values and beliefs. A relationship of fairness, respect, and trust was created between the researcher and the student nurses who volunteered to participate.

1.8.2 Theoretical framework

Although the nursing programme under study is offered at a residential university, the principles supported by Tait's (2000) model of student support in open and distance learning systems, which is underpinned by social constructivist ideas, were used to guide this study. According to Tait (2000:3), student support is a range of services for both

individuals and students in groups, which complements the course materials or learning resources, and which is uniform for all learners. He proposed that the primary functions of student support are cognitive support (which relates to the provision of course materials and learning resources that are up to standard), affective support (which relates to the provision of an environment where students feel committed and comfortable), and systemic support (which relates to the establishment of administrative processes that are effective and student-friendly). Tait (2000) argues that these functions are all essential, and that they are interdependent. This model seems to be relevant, because these three dimensions of student support (cognitive support, affective support, and systemic support) could be related to student support during clinical placement for the bachelor's nursing degree programme. The application of Tait's (2000) model of student support in open and distance learning systems to the clinical training of nursing students in clinical placement is discussed below.

1.8.2.1 Cognitive support

According to Tait's framework of student support (2000:3), cognitive support relates to supporting and developing learning through the mediation of standard and uniform elements of course materials and learning resources for individual students. In this study, cognitive support relates to teaching and learning in the clinical environment that is based on theory provided in the classroom (clinical learning objectives), which clearly reflects clinical teaching/learning and results in the achievement of learning outcomes.

1.8.2.2 Affective support

Affective support, according to Tait's framework (2000:3), relates to providing an environment that creates commitment and enhances self-esteem. Affective support in this study relates to the objective of providing a quality clinical learning environment during clinical placement where students feel comfortable and valued and are able to manage.

1.8.2.3 Systemic support

Systemic support, according to Tait's framework (2000:3), relates to establishing administrative processes and information management systems that are effective, transparent, and, above all, student-friendly. In this study, systemic support relates to the

provision of effective administrative aspects of clinical placement that are relevant to individual and diverse student needs. All three primary functions (dimensions) of student support can be achieved in clinical nursing education with effective planning of nursing student clinical placement support, which is the purpose of this study.

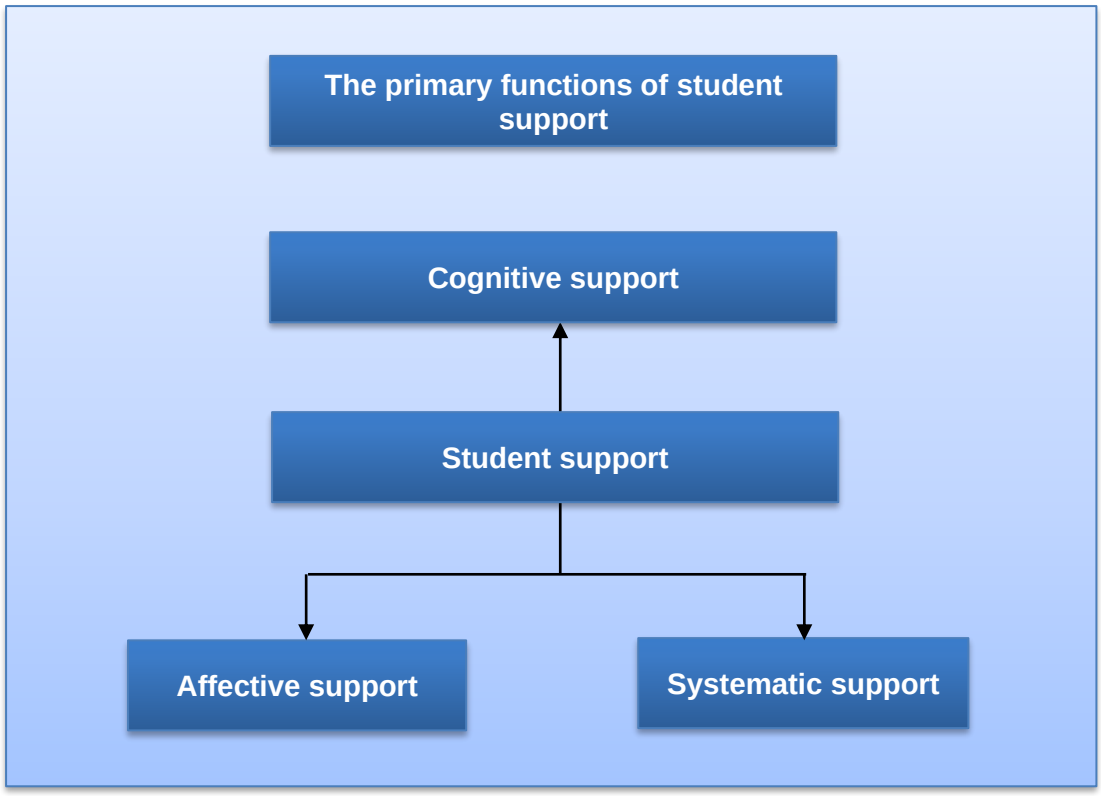

Figure 1.1 Tait's primary functions of student support

(Adopted from Tait's (2000) model of student support in open and distance learning systems)

1.9 OVERVIEW OF THE RESEARCH DESIGN AND METHODOLOGY

In this section, a brief overview of the research design and methodology is provided. The research methods are discussed in detail in the following chapter (Chapter 2).

1.9.1 Research design

A research design is a blueprint for data collection, data measurement, and data analysis (Islam 2019:2). It entails the process of turning an idea into a project (Hammond & Wellington 2013:131). It involves everything from developing the research topic, formulating the research questions, reviewing the literature, deciding on the theoretical

orientation, determining what type of data will be collected and how it will be collected, deciding on the sample, deciding on how the proposed data will be analysed, reaching a conclusion, and, finally, documenting the process and finding an audience for disseminating it (Donley 2012:107). A qualitative, exploratory, descriptive, and contextual design was employed for this study.

1.9.2 Population

A population consists of a group of elements with similar characteristics. Godwill (2015:63) defines a population as a totality of individuals within a given group. The same author explains that research findings are more accurate if the research is based on the entire population within the given group, which Donley (2012:93) terms “population universum”. Donley (2012:92) defines a population as the complete list of elements that the sample will be drawn from. The initial population for this study was all first-year, second-year, third-year, and fourth-year student nurses enrolled for the bachelor’s nursing degree programme at a selected university in Rwanda. However, the first-year students had not attended at least eight weeks of clinical placement, so they had no experience to share. Therefore, the population was only second-year to fourth-year nursing students. The researcher recruited participants who were available to her at the location where the sampling took place. The accessible population from which the sample was drawn consisted of students who were on block at the university campus and were present at the time of data collection.

1.9.3 Sample and sampling technique

A non-probability, purposive, and convenience sampling techniques that adhered to a set of criteria were used to recruit participants. A sample, according to Godwill (2015:63), is a portion extracted from a population with the same characteristics. According to Donley (2012:94), in non-probability sampling, every element in the population lacks an equal chance of being selected. A convenience sample is one that consists of people who are available to the researcher simply because they are at the location where the sampling is taking place (Donley 2012:127). The sample size was determined by data saturation. Cronin, Coughlan and Smith (2015:99) assert that the goal of qualitative research should be the attainment of data saturation.

1.9.4 Data collection

According to Brink et al (2018:132), data collection is very important for a study's success, as it aims to answer the research questions. The same authors explain that the accuracy of a study depends on the quality of the data collection technique(s) used. Creswell and Creswell (2018:604) explain that the data collection process entails that the researcher identify the participants and sites, gain access, determine the types of data to collect, develop data collection forms, and administer the process in an ethical manner. Data was collected through five focus group interviews of six to eight participants per group, using a semi-structured interview guide (see Annexure10).

1.9.5 Data analysis

Qualitative data analysis involves the identification of concepts that emerged in the data collected, and the range of responses in relation to these themes that are being written about in the phenomenon being studied (Patten & Newhart 2018:20). According to Brink et al (2018:165), data analysis entails categorising, ordering, manipulating, and summarising the data, and describing the data in meaningful terms, with the aim of answering the research question. They further explain that qualitative data analysis is a "hands-on" process, because the researcher becomes immersed in the data during the process. According to Creswell (2012:259), the researcher in qualitative studies is required to understand how to make sense of text and images for the researcher to form answers to the research questions. Roller and Lavrakas (2015:235) state that qualitative data analysis occurs in two phases, namely the data generation phase and the data analysis phase.

Data was analysed in accordance with the data analysis cycle of Creswell and Creswell (2018:268-270). To answer the research questions, and to enhance the trustworthiness of the findings, the data analysis steps prescribed by Creswell and Creswell (2018:268-270) were employed by the researcher to analyse the data. Creswell's data analysis cycle is discussed in detail in Chapter 2 according to the following five steps: step 1: organise and prepare the data for analysis; step 2: read or look at all the data; step 3: start coding all the data; step 4: generate a description and themes; and step 5: represent the description and themes.

1.10 ETHICAL CONSIDERATIONS

Ethical considerations in the research process relate to matters of right and wrong, and accountability when research is conducted on people (or animals). Patten and Newhart (2018:35) state that researchers should ensure that they protect participants from both physical and psychological harm. According to Polit and Beck (2012:125), it is imperative for researchers to follow all procedures to adhere to ethical principles in research that involves human subjects. The study was approved by the Unisa College of Human Science Research Ethics Review Committee (see Annexure 1(a)). Ethical principles were maintained to safeguard the rights of the institution and the research sites, as well as to protect and maintain the rights of the study participants. The researcher fully adhered to ethical principles, and the tutorial letter received from Unisa was used to guide her in ethical decision-making during the development of the dissertation.

1.11 TRUSTWORTHINESS

Trustworthiness in qualitative research entails assessing the dimensions of validity and reliability of the study. According to Brink et al (2018:157), trustworthiness in qualitative research can be established when the findings of the study emerge from participants' responses, and not from any preconceptions of the researcher. Trustworthiness was maintained through consistent employment of the underpinning principles of credibility, dependability, transferability, authenticity, and confirmability. The steps taken to adhere to and maintain these principles are described in Chapter 2.

1.12 SCOPE AND LIMITATIONS OF THE STUDY

The scope of the study was one of the three programmes of the School of Nursing and Midwifery in a selected public university setting in Rwanda. The selected university is Rwanda's largest higher education institution, and the head office is in Kigali. The university has nine campuses, which are spread across all four provinces of Rwanda and the city of Kigali. Programmes are shared across these campuses. The population in this study consisted only of nursing students from the bachelor's nursing degree programme at the Rwamagana Campus, which amounted to 512 students. The data collection site was the Remera Campus, located in the city of Kigali. The study focused on the perspective of students. While collecting the views of educators and professional nurses

would have yielded more comprehensive data, such an investigation is beyond the scope of a study at master's level, and it will be undertaken in further research.

1.13 STRUCTURE OF THE DISSERTATION

The report of this study is divided into five chapters, as follows:

Chapter 1: Orientation to the study
Chapter 2: Research methodology
Chapter 3: Presentation of the findings
Chapter 4: Integrated discussion of the findings
Chapter 5: Conclusions, limitations, and recommendations

1.14 SUMMARY

Chapter 1 explained the importance of clinical education, while providing the background on the complexities of teaching and learning in the clinical environment. The importance of student support during clinical placement was reflected on. A justification for the study was provided, as well as background information about the problem that informed the need for the study. A brief overview was given of the research design and methodology. The significance of the study was explained, and key terms used in the study were defined. The metatheoretical assumptions that governed the researcher's actions and thinking, and the theoretical framework that guided her during the study, were also explained. This was followed by a brief explanation of the relevant ethical considerations, as well as the measures taken by the researcher to ensure trustworthiness. Finally, a description of the scope of the study and the structure of the dissertation was given. The following chapter (Chapter 2) focuses on the research design and methods.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

Chapter 1 presented an overview of the study, while providing insight into the background of the research problem. Chapter 2 informs readers about the justification for the chosen research design and methods, and it clarifies the role of the researcher in the study. It explains the reasons why certain protocols were used during data collection, data analysis, and presentation of the results. It provides information about the integrity of the data and the entire study. A description is given of the research methodology that was employed in the study, and specifically the methodological process followed pertaining to the research design, the methodology, the research setting, the study population, the sample of the population, the sampling technique, the data collection, and the data analysis. A detailed account of the measures taken to enhance trustworthiness, and the ethical considerations, is provided.

2.2 RESEARCH SETTING

A research setting is a specific place or places where data is collected (Brink et al 2018:47). The setting for the study was a natural environment. The College of Medicine and Health Sciences of the chosen university is multi-campus. It is situated in Rwanda in three different provinces: Kigali (Remera Campus), Eastern Province (Rwamagana Campus), and Southern Province (Huye Campus). The campuses have an average distance of 124.9 km between them. Students are placed for clinical practice in health facilities (referral hospitals, district hospitals, and health centres) all over the country. It is the joint responsibility of mentors and educators in Rwanda to facilitate students' learning in clinical settings. The study was carried out at the Remera Campus, which is in the Remera Sector of Gasabo District in the city of Kigali, Rwanda. Data was collected in three conference halls at the Remera Campus of the selected university. Islam (2019:12) states that a reader can understand things that relate to the findings of a study better when a map of the research setting is provided.

Figure 2.1 shows the Rwanda's Districts within their respective provinces showing the districts where the campuses of the College of Medicine and Health Sciences, University of Rwanda are located.

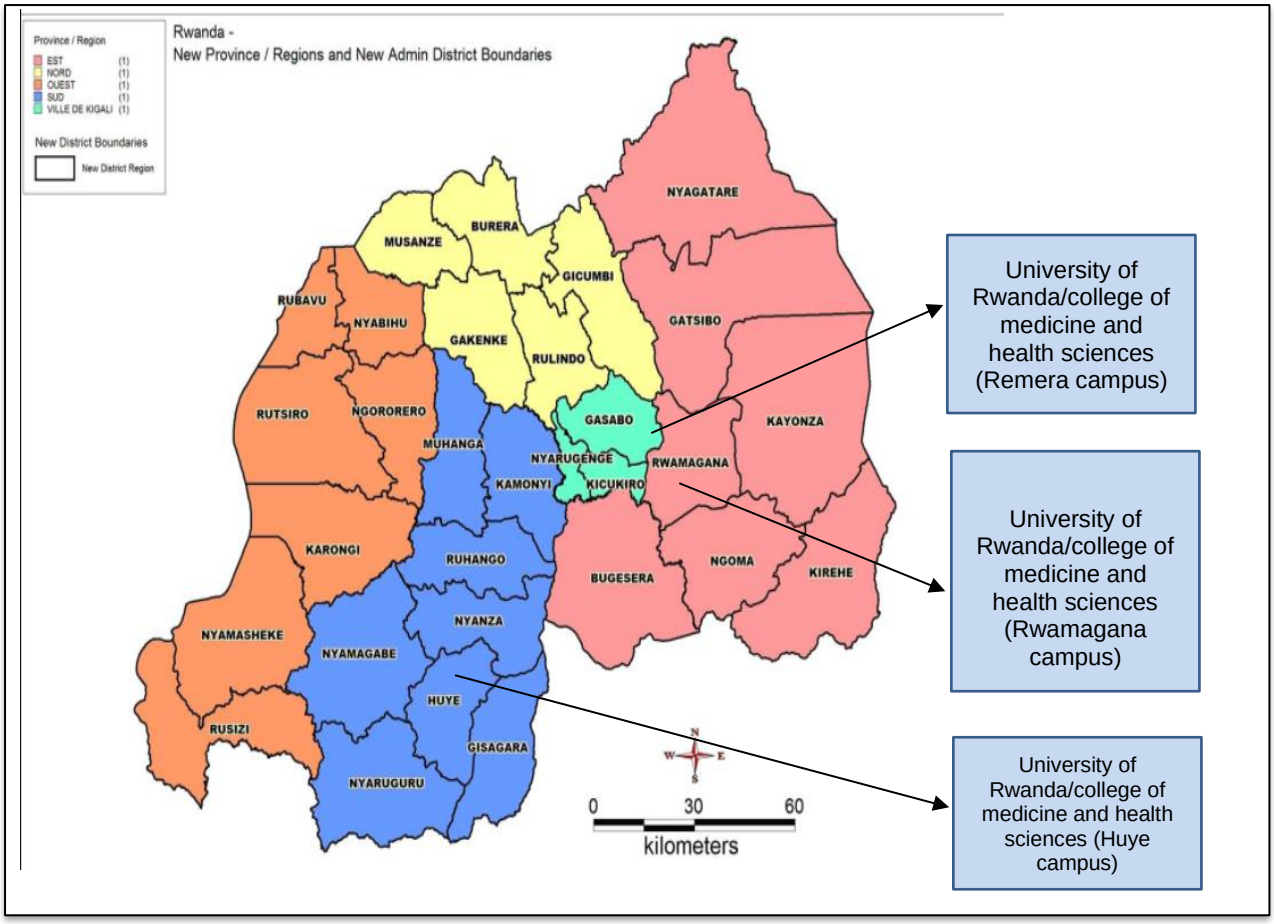

Figure 2.1 Map of Rwanda's Districts within their respective provinces

(Map of Rwanda's Districts [s.a.])

2.3 RESEARCH PURPOSE AND OBJECTIVES

According to Brink et al (2018:50), the research purpose is a single sentence that captures the entity of the study while outlining the study population and the research setting. The research purpose is what the researcher intends to use to address the research problem (Creswell 2012:83). It is generated from the research problem and the research question (Brink et al 2018:50).

The purpose of this study was to propose a student support plan for clinical facilitation to enhance the clinical learning of nursing students registered for an undergraduate nursing programme at a selected university in the Republic of Rwanda.

Research objectives are concrete, measurable ends towards which research is directed, and they are articulated in the present tense (Brink et al 2018:74).

The research objectives that were set for this study are the following:

- To explore and describe the clinical learning experiences of nursing students during clinical placement
- To describe the support needs for clinical learning according to the cognitive, affective, and systemic dimensions of student support
- To draw up a student support plan for clinical placement of students

2.4 RESEARCH DESIGN

A research design entails the process of turning an idea into a project (Hammond & Wellington 2013:131). It involves every step of the research process. The process starts with developing the research topic and ends when the results are disseminated to the right audience (Donley 2012:107). Reflection on the relevance of the set purpose of the research study helped the researcher to decide on a suitable research design for the study. A qualitative, exploratory, descriptive and contextual design was employed to address the objectives set for the study.

2.4.1 Qualitative research

Qualitative research entails a set of interpretive, material practices that make the world visible (Islam 2019:2). Qualitative researchers are required to make informed judgements during analysis of data gathered from participants' responses. A qualitative design is common for setting objectives that explore, describe, and discover the reasons and motivations for perceptions, beliefs, and people's behaviours in a natural environment, while also noting the context in which the behaviour occurs (Donley 2012:39). A qualitative design is suitable for producing a better understanding of people's lived experience (Yin 2016:9). Qualitative research emphasises aspects of meaning, experience, and understanding (Brink et al 2018:3), rather than producing statistically meaningful results (Donley 2012:39). Creswell (2014:32) considers qualitative research an appropriate approach when a researcher seeks to explore and understand the

meaning that individuals or groups ascribe to a social or a human problem. Researching the clinical learning experiences of student nurses called for direct involvement and close interaction with the research participants in a natural environment. During the interaction with the participants, the researcher gained insight into the participants' clinical learning experiences and the meaning they make of these experiences. This insight helped the researcher achieve the objectives set for the study. The answers to the research questions were not quantifiable, and they resulted in textual data. Therefore, the qualitative design provided a deeper understanding of student nurses' support needs in the clinical environment. The final report was narrative, with contextual descriptions and direct quotations from the research participants. Creswell (2014:32) highlights the need for flexibility in the structure of the final written report when a qualitative approach is used.

2.4.2 Exploratory design

An exploratory design stresses the discovery of ideas and insights (Huttlinger 2012:169). This means that a research design appropriate for exploratory studies should be flexible enough to allow opportunities for considering various aspects of the problem under study. According to Polit and Beck (2018:67), exploratory research is suitable for investigation of the full nature of the phenomenon being studied, rather than simple observation and description of the phenomenon. The same authors explain that the fact that an exploratory study is conducted implies that not enough has been written about the topic or the population being studied. An exploratory design was chosen for this study because the researcher seeks to gain insight into and an in-depth understanding of nursing students' support needs in the clinical setting, because little is known about their support needs in the Rwandan context. Data was collected through five focus group interviews, where a semi-structured interview guide was used to allow for flexibility, to consider different aspects of the problem. Flexibility was ensured by using an interview guide with open-ended questions, rather than a strict schedule. Participants were also allowed to express their views, and their questions were answered. Hence, the focus group interviews allowed for exploration and discovery of participants' views and experiences.

2.4.3 Descriptive design

Descriptive research is suitable for description of a social phenomenon of interest, and it typically constitutes the first studies done on a given topic (Donley 2012:127). It provides

the reader with a context on which to base theory, and it adds value to exploratory research when little is known or has been articulated about the context (Hammond & Wellington 2013:45). The search for relationships between a phenomenon and other phenomena can be meaningful after thorough exploration and description of that phenomenon. Descriptive data includes people's own written or spoken words and observable behaviour (Taylor, Bogdan & DeVault 2016:165). Since little is known about nursing students' support needs in the clinical setting in Rwanda, this study explored and described students' clinical learning experiences, trying to establish students' support needs in the clinical setting in the Rwandan context. Data was gathered through focus group discussions, which included observing and describing participants' behaviour through handwritten field notes.

2.5 RESEARCH METHODS

For the researcher to collect and analyse data, it was necessary that the procedure for doing so be decided upon from the start. These procedures are called research methods. Patten and Newhart (2018:20) state that qualitative research methods involve researchers using their informed judgement after data gathering to identify concepts that consistently emerge in the data in relation to themes written in the analysis of the phenomenon being studied. The researcher decided on a research method with full cognisance that each method has its own philosophical and theoretical basis (Danchev & Ross 2014:87). According to Manning and Kunkel (2014:159), research methods should always be directly linked to the research question.

2.5.1 Population

A population refers to a defined set of objects or individuals that are the focus in any field of inquiry (Godwill 2015:63). Donley (2012:92) defines a population as the complete list of elements that the sample will be drawn from. Cronin et al (2015:89) explain that since a population is deemed to have one or more common characteristics, it therefore can be considered a group. The population for this study was undergraduate second-year to fourth-year nursing students at a selected university in Rwanda. An accessible population is a population to which the researcher has access to study (Brink et al 2018:116). According to Cronin et al (2015:89), an accessible population is the group from which the sample will be drawn. The accessible population for this study was first-year, second-

year, third-year, and fourth-year nursing students enrolled for the bachelor's nursing degree programme at the selected university in Rwanda, which amounted to 521 students. Students were eligible to participate if they met the following criteria:

- They were first-year, second-year, third-year, or fourth-year students registered for the bachelor's (undergraduate) nursing programme leading to registration as a nurse, at the selected university in Rwanda.
- They had attended clinical placement for at least eight weeks.
- They were at least 18 years of age.

According to Cronin et al (2015:89), eligibility criteria are the characteristics that help define the individuals that fit in the population. Nursing students registered for the bachelor's degree nursing programme leading to registration as a nurse who had attended at least eight weeks of clinical placement were included. The set criteria were necessary to ensure that participants had sufficient clinical placement experience that they could draw on to share their experiences regarding the support they need during clinical placement. All first-year students were excluded, because they had not attended up to eight weeks of clinical placement, and therefore they had not been exposed to different clinical settings.

2.5.2 Sample selection

A sample, according to Godwill (2015:63), is a portion extracted from a population with the same characteristics. Brink et al (2018:117) explain that a sample is made up of a selected group of elements from a defined population. The sample in this study was extracted from all the nursing students who met the inclusion criteria at the selected university. According to Cronin et al (2015:89), inclusion criteria are characteristics of the targeted population set by the researcher to distinguish those who will be part of the population.

2.5.3 Sampling

Sampling is a process of selecting, from the population, participants for a study, using a sampling design (Godwill 2015:63). Sampling in qualitative studies entails deciding who is to be interviewed or observed, and it is important for the researcher to be familiar with

the knowledge and experiences of potential participants (Morse & Nichaus 2016:63). According to Creswell and Creswell (2018:291), the purpose of sampling in qualitative studies is in-depth exploration of the phenomenon being studied. The process of selecting participants in this study was decided on, with the focus on intentionally selecting participants that were knowledgeable about the phenomenon being studied. A non-probability, purposive, and convenience sample was used to select participants.

2.5.3.1 Non-probability sample

Non-probability sampling is a sampling procedure that has no basis for estimating the probability that each item in the population has of being included in the study (Cronin et al 2015:90). It is based on certain decisions that may depend on the researcher (Godwill 2015:70). According to Donley (2012:94), in non-probability sampling, every element in the population lacks an equal chance of being selected. Non-probability sampling may or may not accurately represent the population, depending on the researcher's ability to access and select participants that are most knowledgeable about the phenomenon being studied (Brink et al 2018:124).

2.5.3.2 Purposive sample

A purposive sample is a type of non-probability sampling, and it is used when the researcher is seeking specific knowledge (Brink et al 2018:126). When individuals who have experienced the phenomenon being studied are selected, it becomes most beneficial to the study (Cronin et al 2015:90). The researcher purposefully selected nursing students who had been exposed to the clinical setting for at least eight weeks, to ensure that they had sufficient clinical placement experience that could help them develop clinical learning experiences and share these experiences. During recruitment of participants, the researcher purposefully ensured that participants from the second year to the fourth year of study in the bachelor's degree nursing programme were included in the sample. In purposive sampling, the cases are selected based on the researcher's judgement (Islam 2019:13). The gatekeeper had a list of all second-year to fourth-year students, with their contact information. The gatekeeper contacted and recruited participants who were willing to participate, while ensuring both homogeneity and heterogeneity in the constitution of each focus group interview. Three of the five focus groups interviews were homogeneous, and two were heterogeneous. This allowed the

researcher to gain a comprehensive picture of students' support needs, as well as insight into students' needs by year of study. The researcher was interested in gaining a comprehensive picture of students' support needs in clinical placement, because this is the first study on this subject and this population carried out in Rwanda. Recommendations for further studies according to year of study are made.

2.5.3.3 Convenience sample

A convenience sample is a sample that consists of people who are available to the researcher simply because they are at the location where the sampling is taking place (Brink et al 2018:125; Donley 2012:127). In a convenience sample, the researcher tends to select participants because they are willing and available to participate (Creswell 2012:168). Cronin et al (2015:96) explain that a convenience sample is a reasonably inexpensive and quick way of obtaining a sample. However, a convenience sample has the potential to increase sampling bias. Sampling bias occurs when the researcher decides to choose who to approach or to include in the study (Cronin et al 2015:96). To overcome sampling bias, gatekeepers were used to recruit participants. The researcher depended on the availability and the willingness of participants who were present at the time of data collection at the university campus where data was collected. The selected university was conveniently chosen because it trains the highest number of nurses at the bachelor's level in Rwanda, making it an obvious choice to understand issues that are related to the training of nurses to have a big impact in the country.

2.5.4 Sample size

According to Brink et al (2018:128-129), arbitrarily choosing a sample size in qualitative research may adversely affect the research study, as having too many participants will increase the complexity of the data analysis process, while having too few participants may make it possible for the researcher to observe the identity of the participants. The same authors advise that researchers should keep recruiting participants until they reach a point at which new data no longer emerge. The sample size in this study was therefore guided and determined by the principle of data saturation. Data saturation in this study occurred when most of the focus groups yielded no new themes on the phenomenon being studied (Cronin et al 2015:99). This means that in most of the focus groups participants' descriptions about the phenomenon being studied kept repeating and

echoing previously collected data. A total of five focus group interviews were conducted, and 35 participants altogether participated.

2.5.5 Data collection

The data collection process in qualitative research entails setting boundaries for the study, through sampling and recruitment of participants, as well as establishing a protocol for recording the data (Creswell & Creswell 2018:262). According to Brink et al (2018:132), the accuracy of a study depends on the quality of the data collection technique(s) used. This means that data collection is at the core of a research study (Cronin et al 2015:129). Data generation happens during data collection, as it provides the researcher with information needed for the study (Godwill 2015:79). Creswell (2012:204) explains that the data collection process entails that the researcher identifies the participants and sites, gains access, determines the types of data to collect, develops data collection forms, and administers the process in an ethical manner.

2.5.5.1 Data collection approach

Unstructured interviews are narrative interviews that allow participants to respond to a general question without interruption (Morse 2015:29). Focus group interviews were used as the method of data collection. According to Flick (2015:147), a focus group interview is a group interview in which many participants are asked the same question, and answers are provided by individual participants, one after another. For the researcher to understand the support needs of nursing students for clinical facilitation to enhance their clinical learning, it was necessary that they participate in focus group interviews. According to Flick (2015:140), an interview is needed to obtain participants' individual views about the phenomenon being studied. Focus groups were chosen over individual interviews because the researcher believed that focus groups would yield rich, in-depth information. Patten and Newhart (2018:164) state that focus group interviews are beneficial for the fact that during these interviews, evolution of perceptions is revealed in a social context. According to Flick (2015:147), in a focus group interview, participants are more likely to express themselves and to elaborate on their statements than they would in an individual interview. This happens because when a participant states their experiences, other participants listen, and their own memories are stimulated. During this process, participants can learn from one another, and can alter or change their views

about the topic being discussed (Cronin et al 2015:141). Cronin et al (2015:141) state that the researcher (the moderator) should ensure that everyone participates, as dominant participants may lead other participants to submit to their views. In this study, the focus group interview was initiated with a grand tour question. The study participants then indicated by a show of hands when they had something to say, and they elaborated spontaneously on their individual experiences during clinical placement.

Group interaction stimulated the memories of other participants. The responses of individual participants built on one another's responses, enabling individual participants to reflect on the views and perceptions of other participants and to appraise them against their own understanding.

2.5.5.2 Interview guide

The interview guide in this study (see Annexure 10) was a semi-structured list of topics that the researcher planned to cover during the focus group discussions that could help achieve the purpose set for the study. In a semi-structured interview approach, an interview guide is formulated in advance (Patten & Newhart 2018:162). The interview guide was developed from the research purpose, the research objectives, and the research questions, as well as from an initial partial review of the literature. The literature was partially reviewed to prevent preconceived ideas during data analysis. Creswell and Creswell (2018:66) states that an initial review of the literature in qualitative research serves as a framework and helps the researcher to establish the importance of the study. Tait's (2000) model of student support in open and distance learning systems was incorporated into the interview guide. The topics were covered through open-ended questions, which were categorised into three dimensions: the cognitive, the affective, and the systemic dimensions. Probing questions were asked to seek details on issues raised. The interview guide was divided into four sections: an introduction, a welcome, the questions, and the closing.

2.5.5.3 Pretesting of the focus group interviews

A pretesting of the focus group interviews was conducted in August 2020, to help the researcher test the practical aspects of the focus group and the questions, to identify flaws. According to Brink et al (2018:161), failure to detect possible flaws in the

methodology of a study may be costly in the actual study. A focus group interview was held with four individuals who met the inclusion criteria but were not part of the selected participants. During this process, the researcher, who was also the moderator of the focus group, tested her interviewing skills, the interview questions, and the functioning of the audio-recording device. The pretesting of the focus group interview took about 30 minutes.

The analysis of the data collected during the pretested focus group interview yielded three themes: support needed during clinical placement, clinical placement experiences regarding support needed, and suggestions to enhance clinical placement. The results of the pretested focus group interview revealed that the interview questions were indeed focused on the objectives set for the study. Accordingly, no modifications were made to the interview questions. However, the assistant focus group moderator made comments in the field notes regarding the volume of the recording device, the need to create a document that could be used to collect demographic information from participants after the focus group interview, and the need to randomly assign numbers to participants during each focus group interview. Focus group interviews should include a part in which relevant demographic information is collected (Patten & Newhart 2018:163). Assigning numbers would serve the purpose of anonymously identifying each speaker, and it therefore gave a structure to the audio recordings during transcription, it facilitated the referencing of quotations, and it ensured the inclusion of dissimilar quotations during report writing.

2.5.5.4 Planning of the focus group interviews

A focus group is a method of qualitative data collection in which participants are interviewed in groups, and it is characterised by social and dynamic interaction (Cronin et al 2015:141). The selected university, like other universities and research institutions in Rwanda, is delegated by Rwandan regulations to affiliate researchers from outside Rwanda who are not Rwandan nationals and facilitate ethics clearance and research clearance. A letter was addressed to the Director of Research and Innovation at the chosen university, in which application was made for research affiliation and permission to access the research population and data collection site (see Annexure 2). By virtue of the affiliation granted (see Annexure 3), permission to access the research participants and the research site was granted through the line manager of the Dean of the School of

Nursing and Midwifery. A local supervisor was then appointed for the researcher from the selected university (see Annexure 4).

The researcher's planning of the focus group started with pre-focus group meetings with the researcher, the assistant focus group moderator, and the researcher's supervisors. During these meetings, the Covid-19 safety measures that would be enforced during the focus group interviews were emphasised. The researcher wrote down prevention measures for Covid-19 that would be followed to ensure a safe environment for all who would be involved in the focus group interviews. A Covid-19 compliance letter (see Annexure 14) was addressed to the Unisa College of Human Sciences Research Ethics Committee (CREC), outlining these measures.

The roles of the moderator and the assistant moderator were identified and clearly defined, and their ability to carry out these roles effectively was assessed. The assistant focus group moderator was already experienced in conducting focus group interviews. However, the moderator and the assistant focus group moderator were both trained by the Researcher's local supervisor who is experienced in qualitative research on how to carry out their roles. Patten and Newhart (2018:164) explain the responsibilities of an assistant focus group moderator as being to operate the recording equipment, to take field notes, and to document relevant aspects of the dynamics within the group that could help the researcher with data analysis and interpretation. A participant recruitment plan was then developed. A list of second-year to fourth-year students enrolled for the bachelor's degree programme leading to registration as a nurse, and the students' contact information, was provided to the gatekeeper (who was also the assistant focus group moderator). To ensure social distancing, a WhatsApp group was created for each year of study, through which information was shared about the purpose of the study, through a shared copy of the information sheet (see Annexure 5). Students who were interested in participating in the study indicated this to the gatekeeper through WhatsApp messaging. The researcher purposively planned for both homogeneous focus group interviews (participants belonged to the same year of study) and heterogeneous focus group interviews (participants were a mix of all years of study), and participants were recruited accordingly (see Table 3.1). Since this study was the first study of its' kind in Rwanda, the researcher was interested in a comprehensive picture regarding the support that students need during clinical placement. Interested participants were contacted in advance, they were recruited for the study, and the venue and the time were

communicated to them. Each focus group was made up of six to eight participants. Recruitment of participants continued until data saturation was reached.

2.5.5.5 Conducting the focus group interviews

A quiet conference hall which was accessible to participants was booked at the Remera Campus. Comfortable seats were arranged in such a way that the participants were able to look at each other when speaking, so that they could pick up both verbal and non-verbal cues. A distance of 1.5 metres between participants was maintained to ensure social distancing. The researcher and the assistant focus group moderator positioned themselves where they could observe the participants while they spoke. Light refreshments were provided to participants to keep them comfortable and happy during the focus group interviews. There was a temperature control and handwashing point at the entrance to the university, where everyone washed their hands and had their temperatures taken. All the participants were required to wear their face masks throughout the focus group interviews, except when they were eating. All the windows in each conference hall where the focus group interviews took place were kept open, to ensure free circulation of air. Hand sanitisers were made available at the door into each conference hall where the focus group interviews were held. Five focus group interviews were conducted between September and November 2020. The focus group interviews took place in conference halls at the Remera Campus of the selected university.

All the focus group interviews started at 11 am, and each lasted about 90 minutes. Each focus group interview consisted of six to eight participants. A total of 35 students from the second year, the third year, and the fourth year of study volunteered to participate in the focus group interviews. First-year students did not participate in the focus group interviews, because they had not attended at least eight weeks of clinical placement. Therefore, they had no experience to share. The first three focus groups were each composed of participants from the same year of study, while the last two focus groups were each a mix of participants from all years of study. Not much has been written about the topic and the population studied. The study is the first of its kind to be carried out in Rwanda, so the researcher was interested in gaining a comprehensive picture of nursing students' support needs during clinical placement. However, some flexibility was allowed, in that the researcher had three homogeneous focus group interviews, which allowed her to gain insight into the support needs of students according to year of study, to see

whether there is a difference in student support needs during clinical placement between junior and senior students.

- **Beginning of the focus group**

All focus group interviews were conducted in English. The researcher introduced herself to everyone. The purpose of the research and the focus group was explained. Each participant was given an information sheet (see Annexure 5) to read a summary of the aim of the research, what participation in the research meant, the risks associated with participating in the study and the inconvenience that could be expected to result from participation, the benefits for participants, and how confidentiality would be maintained. Time was allowed for participants to read the information sheets and make an informed decision about participating in the study. The researcher reminded participants that participation was voluntary and that any participant could withdraw from the study at any time without giving any reason and without being subjected to any form of punishment. Participants that volunteered to participate indicated this by a show of hands, and they were given consent forms (see Annexure 6) to sign. Patten and Newhart (2018:35) state that individuals should be free to make choices and to participate in research voluntarily. The same authors explain that informed consent is essential for promoting ethical value in a study.

The researcher then confirmed with participants whether the focus group interviews could be audio-recorded. Patten and Newhart (2018:164) explain that it is necessary to record the focus group interview, so that the focus group moderator can focus on the complex task of facilitating the discussion. The audio-recording device was set, and each focus group interview session started with the following grand tour question being posed (see Annexure 10):

“Please share with us your clinical learning experiences regarding the support you need during clinical placement, and how you think your clinical placement can be enhanced.”

The researcher encouraged participants to freely express their views and understandings regarding their experiences with the support they need during clinical placement, and how they think their clinical placement can be enhanced. The discussions during the focus

group interviews were initiated with a single view, which led to another view and gradually evolved into full-scale discussions between the participants. Probing questions were asked to extract more information from shy participants and to seek clarification on points raised during the focus group interviews, which enabled the construction of multiple realities from the participants' views.

- **After the focus group**

The researcher thanked everyone for their time and participation. The main views that were shared in the focus group interview were highlighted as a takeaway of the focus group interview session. The attendance list document, which had a section that solicited demographic information from participants, was filled in and signed. Participants were given information on how to contact the researcher and how the preliminary coding draft would be shared, for them to verify the accuracy of the data and the interpretation thereof. Participants were assured that the results of the study would be made accessible to them.

2.5.6 Field notes

One of the roles of the assistant focus group moderator was to write down the verbal and non-verbal observations of the topics that were discussed at the time the focus group interviews took place. These handwritten notes are called field notes. Field notes were important for this study to remind the researcher of the events and happenings at the time of data collection that were important during data analysis. The field notes taken during the five audio-recorded focus group interviews provided the context for interpretation of the interviews. The researcher read the field notes while listening to the audio recordings during the data generation phase (Roller & Lavrakas 2015:235), which reminded her of the situational factors that were important during the interviews.

2.5.7 The role of the researcher

According to Cronin et al (2015:146), the role of the researcher in qualitative research is to try to be objective, that is, to consider the thoughts, feelings, and responses of the research participants. The researcher becomes involved in the research, so they may unduly influence it. It is therefore important for the researcher to acknowledge and bracket their own thoughts, feelings, and experiences. To overcome researcher bias, Cronin et al

(2015:146) recommend critical reflection on the part of the researcher. In this study, the researcher was the main instrument of data collection, with an etic role. Given the researcher's past experiences as a student nurse, a nurse, and a nurse instructor, the memory of her own feelings, thoughts, and experiences could have been stimulated, which could have unduly influenced the study through reflection of her own preconceptions. However, the researcher's personal experience helped her to form a filter through which data was examined. Morse (2015:28) states that researcher bias can be beneficial to maximise the phenomenon being studied. A reflexive journal (see Annexure 13) was kept, in which the researcher wrote down her personal reactions and reflections, which were then bracketed. Sufficient reflexivity occurs when researchers take notes during the process of research, reflect on their past experiences, and consider how these experiences influenced their interpretation of the research results (Creswell & Creswell 2018:260).

2.5.8 Data analysis

Data analysis enables the researcher to provide meaningful interpretation of the data gathered (Godwill 2015:94). In this study, data analysis was essential to provide answers to the research questions posed at the beginning of the study (Cronin et al 2015:147). According to Flick (2015:164), content analysis is the classification of text by allocating statements, sentences, or words to a system of categories. The researcher and the co-coder, who is a senior researcher experienced in qualitative research, both independently analysed the data. The co-coder signed a confidentiality binding form (see Annexure 9). Zoom meetings were held between the researcher and the co-coder about emerging themes, and discrepancies were discussed until consensus was reached.

In this study, the data analysis cycle by Creswell and Creswell (2018:268-270) was applied as follows.

2.5.8.1 Step 1: Organise and prepare the data for analysis

Data organisation and preparation was ongoing throughout the data collection process. Audio recordings were transferred from the recording device, they were named according to the focus group number and the participating year of study, and they were saved in a folder on the researcher's private laptop. To ensure access control, a password, which is

only known to the researcher, was used to secure the laptop and the folder in which the recordings were saved. Secure copies of the recordings were made and stored in Google Drive and OneDrive. The audio recordings were deleted from the audio-recording device.

Hard copies of individual focus group interviews, including the signed consent forms, the field notes, attendance lists, the signed assistant moderator confidentiality binding form, and the handwritten reflexive notes of the researcher, were all labelled according to the focus group number and the year of study of the participants and separately filed and put in one folder and locked in a cupboard.

The process of securing the data was followed by transcription of the audio recordings. The researcher personally transcribed all the audio recordings, using the Descript transcription software, which helped her to play and replay while listening and typing in Word documents, following the same naming convention as the saved audio-recorded files. Transcription of all five focus group interviews took about four months to finish. The transcribed data was shared with the co-coder, who signed a confidentiality binding form (see Annexure 9).

2.5.8.2 Step 2: Read or look at all the data

Creswell and Creswell (2018:268) state that step 2 is where the researcher gets a general sense of the data and an opportunity to reflect on its overall meaning. In this step, the researcher read the focus group interview transcripts repeatedly while she listened to the audio recordings. The field notes were also read while she listened to the audio recordings, to ensure consistency of the data between the oral and the written communication. The interview audio recordings were indeed all consistent with the field notes taken during the interviews. After repeated listening, the researcher gained an understanding of the complete content of the data.

2.5.8.3 Step 3: Start coding all the data

Coding is a process of organising data, by taking textual data, segmenting sentences into categories, and labelling those categories into terms (Creswell & Creswell 2018:269). The researcher identified sections of text with similar words and sentences in the data and highlighted them. Then, relationships between the highlighted sections were reflected

upon, and labels were formulated (coding). The researcher then identified patterns in the codes, which could be brought together to form concepts (subcategories). Then, the researcher identified patterns in the codes, which formed concepts (subcategories). The researcher then combined and named the patterns (categories). Segments of data from the same interview session or different interview sessions that were related according to topic, events, or responses were separated and grouped together to form a category.

2.5.8.4 Step 4: Generate a description and themes

Those patterns that appeared often in the data was kept, and those patterns that did not appear often and did not have any relationship with other patterns or did not make sense were discarded. Categories that resonated with a broader meaning of the data was then grouped together and given a collective name (a theme).

2.5.8.5 Step 5: Present the description and themes

The researcher then wrote down in the passive voice the narrative of the findings that emerged from the data analysis process. The themes, categories, and subcategories were described in detail. The descriptions were supported with quotations from the multiple perspectives of individual participants. The findings of the study are presented in Chapter 3 according to the themes, categories, and subcategories that emerged during the data analysis process.

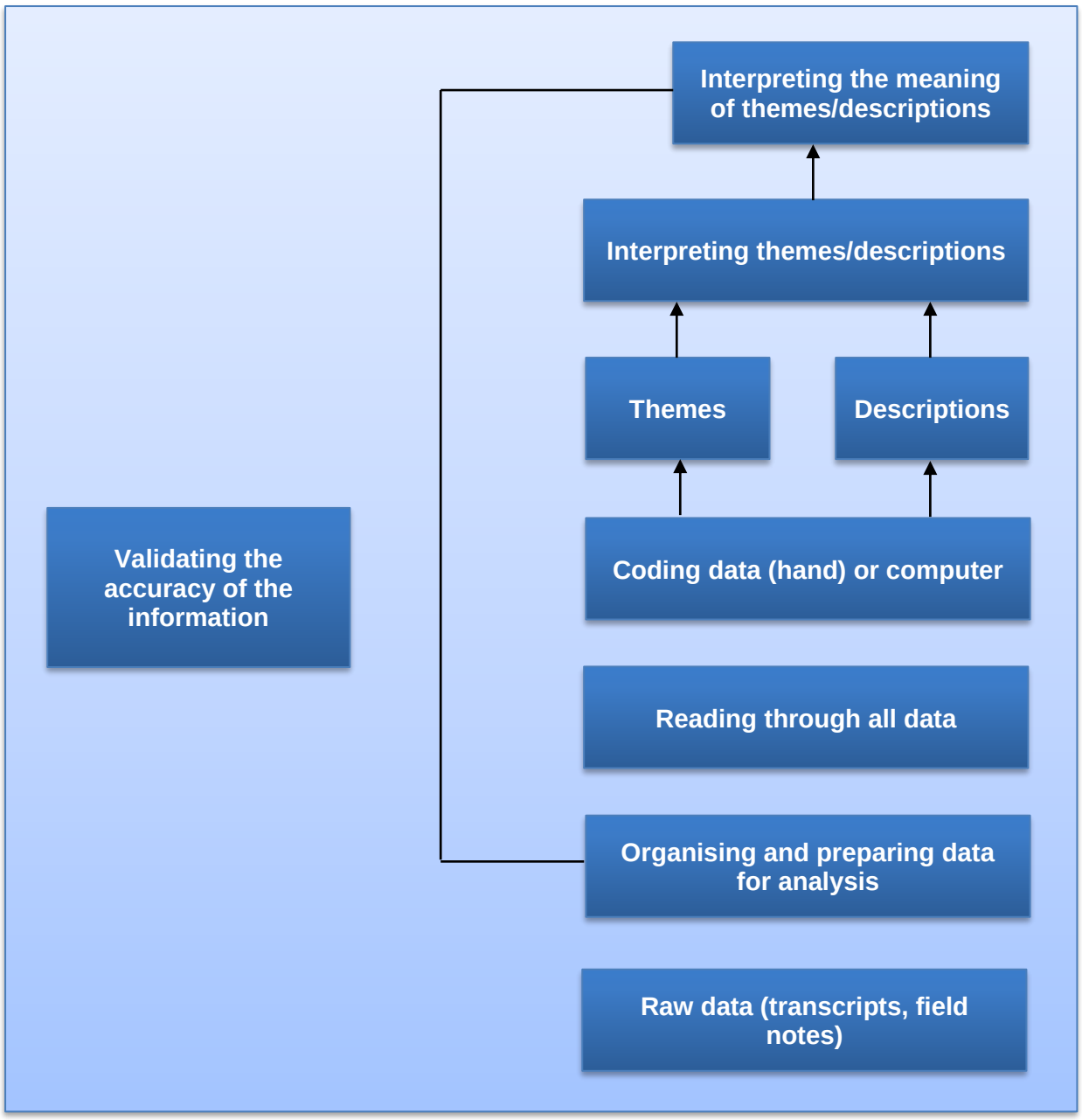

Figure 2.2 Creswell's cycle of data analysis

(Creswell & Creswell 2018)

2.6 TRUSTWORTHINESS OF THE STUDY

Trustworthiness in qualitative research refers to the steps taken by the researcher to demonstrate that the study findings reflect the experiences and views of the participants, rather than the researcher's preconceptions (Brink et al 2018:157). It assesses the dimensions of validity and reliability of the study. Trustworthiness ensures that a study is carried out using standard procedures that are acceptable in qualitative research, and that adequate justification is provided for variations (Connelly 2016:435). This means that

the qualitative research methods used have been explained in detail, allowing for replication of the study, and thus application of the findings (Roberts, Dowell & Nie 2019:21). The measures used to ensure trustworthiness in this study are those prescribed by Lincoln and Guba (1985), as discussed in Brink et al (2018:157-160). These measures include the techniques used by the researcher to ensure credibility, dependability, transferability, confirmability, and authenticity, which are discussed below.

2.6.1 Credibility

In addressing credibility, investigators attempt to demonstrate that a true picture of the phenomenon under study is presented (Morse 2015:19). Credibility examines the extent to which the researcher has followed acceptable procedures in data collection and interpretation (Brink et al 2018:157-158). Brink et al (2018:158-159) state that credibility can be ensured through prolonged engagement, accurate description, member checking, triangulation, persistent observation, and peer debriefing.

The researcher ensured that the data, the interpretation of it, and the conclusions drawn are believable, by utilising the following measures. The researcher worked together with her supervisors, who are researchers, in planning the study. Sufficient time was spent with the data during the data collection and data analysis process. The researcher personally collected the data and transcribed and analysed it.

Thick description of the data was done. Morse (2015:18) states that thick description of the data is essential for transfer of the findings from the original research to another context. A detailed description of the themes, categories, and subcategories that emerged from the data was done, and it was supported by quotations from multiple perspectives of individual participants. The data was member-checked with the participants, by sharing the first draft of the study findings with them, so that inconsistencies could be resolved. A WhatsApp group called “The research team” was created by the researcher with all the participants of the study and the assistant focus group moderator. The first draft of the study findings was shared via this group, for participants to read. Kuada (2012:101) states that the data collected should be validated with the research participants. Data was cross-verified with related literature.

2.6.2 Dependability

Dependability, according to Morse (2015:19), refers to the ability to obtain the same results if a research study were to be repeated. This means that qualitative researchers should strive to enable future researchers to repeat the study. According to the literature, it is difficult to meet this criterion in qualitative research. Brink et al (2018:111) recommend keeping an audit trail, so that the auditor of the inquiry will be able to follow the process and procedures used in the study, to know if they are acceptable. According to Lincoln and Guba (1985), dependability can be ensured through code recording, doing thick description, and triangulation. To ensure dependability, a detailed record of all phases of the research process was kept, which serves as evidence that the study was conducted in an acceptable manner. The audio recordings of the focus group interviews, the hard copies of all the handwritten documents, and the report of the research project were carefully kept in case of an audit. The researcher and the co-coder, who is an experienced qualitative researcher, independently coded the data, and consensus was reached. Themes that emerged from the study were verified by the researcher's supervisor, who is a senior and experienced researcher.

2.6.3 Transferability

Transferability ensures that the findings of a study can be transferred to another situation or population (Morse 2015:19). According to Brink et al (2018:111), transferability determines whether the conclusions of a study are transferable to other contexts. Transferability enables future researchers to determine whether the study findings hold true in other contexts (Kuada 2012:101). Fieldwork in this study occurred during the data collection process. Focus group interviews were used as the data collection method. Details of the context of the fieldwork are described. A purposive and convenience sampling method was used, to ensure that participants were knowledgeable about the phenomenon under investigation, which maximised the amount of information collected about the context. The researcher's experiences during data collection are thoroughly described in the data collection section of this research report. The assumptions that were central to the research study are clearly explained in the section on the foundation of the study.

2.6.4 Confirmability

Triangulation and keeping an audit trial are central to ensuring confirmability in a study (Morse 2015:18). According to Brink et al (2018:111), confirmability ensures that the study findings, conclusions, and recommendations are supported by the data. This means that researchers must strive to ensure and demonstrate that the findings from the study emerged from the data, and not from their own preconceptions.

To ensure confirmability, the researcher kept an audit trial, which details all the data analysis steps that influenced her decisions. This was done by keeping all the recorded actions and field notes taken during data collection, to preserve them as evidence for whenever it is needed. The findings were member-checked, to ensure that they accurately portray participants' responses. The researcher constantly confirmed with participants during and after the focus group interviews, by highlighting the key takeaway points that were shared during each focus group interview session, by mentioning the main points and asking "not so?"

Triangulation was done by using recent relevant literature to compare and contradict the findings of the study. Self-transcription of the audio recordings of the focus group interviews enabled the researcher to engage longer with the data, to grasp the reality of the data as conveyed by the participants.

2.6.5 Authenticity

Authenticity is the researcher's way of establishing the realities and experiences of the study participants. Brink et al (2018:110) refer to authenticity as a measure to ensure internal validity in qualitative research. To ensure authenticity, the evidence addressing the research purpose was supported with direct quotations from the research participants. Varied individual verbatim quotes of participants' views and perceptions about their support needs during clinical placement were appraised with recent literature, to contextualise multiple realities in authentic findings. Using focus group interviews allowed for articulation of different realities of participants' views and perceptions of the support they need during clinical placement, which enabled the researcher to build a comprehensive description of their experiences.

2.7 ETHICAL CONSIDERATIONS

Ethical considerations relate to issues of privacy and confidentiality (Islam 2019:15). As researchers, we are required to adhere to ethical principles. Ethical clearance was obtained from the university of South Africa college of Human Sciences Research Ethics Committee (see Annexure 1(b)). Permission to conduct the study at the university of Rwanda and access to participants was obtained from the Director of Research and innovation, University of Rwanda (see Annexure 2). An information sheet which contained information about the study was made available to participants and informed consent was obtained from participants (see Annexures 5 and 6). A confidentiality binding agreement was signed by the Researcher, the assistant focus group moderator, and the co-coder to prevent confidential information about the study from being disclosed to third parties (see Annexures 7, 8 and 9).

Fostering the ethical skills of qualitative researchers is important, because the integrity of the researcher is the deciding factor, which depends on the researcher's ethical judgement (Willig & Rogers 2017:6). According to Polit and Beck (2012:125), researchers should understand and follow all procedures to adhere to ethical principles in research that involves human subjects. Cronin et al (2015:100) explain that ensuring that studies adhere to ethical principles provides safety, welfare, and rights to the participants, as well as protection to the researcher. Patten and Newhart (2018:35) state that researchers should strive to ensure that research participants are treated with fairness and are protected from physical and psychological harm.

2.7.1 Institutional permission

Since the 1960s, research ethics committees have become responsible for scrutinising research studies that involve humans. These committees have the responsibility for approving, rejecting, or making recommendations for amendments to, research studies (Cronin et al 2015:111). Ethical clearance (see Annexure 1) to conduct the study was obtained from the University of South Africa, where the researcher is a registered student, and from the University of Rwanda, where the researcher is an affiliate (see Annexure 3).

2.7.1.1 Ethical clearance process

After the researcher had crafted and refined the research proposal for the study, it was submitted to the then Research Ethics Committee of the Department of Health Studies at the University of South Africa (see Annexure 1(b)), and ethical clearance was granted. After ethics approval was received, a change was made to the title of the study. A new ethics certificate was issued by the University of South Africa College of Human Sciences Research Ethics Committee, which contains the changed title (see Annexure 1(a)). The Director of Research and Innovation, University of Rwanda, through the line manager of the Dean of the School of Nursing and Midwifery, granted ethics clearance and research clearance by virtue of research affiliation (see Annexure 3) to the researcher to carry out the study at the University of Rwanda.

2.7.2 Ethical principles

Researchers are guided by ethical principles, which are based on participants' human rights, which need to be protected in a study. According to Brink et al (2018:29), ethically acceptable research should be based on the principles of respect for persons, beneficence, and justice. These principles are articulated in the Belmont Report. Ethical principles ensure participants' right to self-determination, their right to be protected from harm, and their right to fair selection and treatment. Participants in this study were nursing students who interacted with the researcher, and it was therefore necessary for the researcher to adhere to these ethical principles, to ensure that participants' rights were protected.

2.7.2.1 Respect for persons

Respect for persons refers to the right to self-determination and full disclosure. Self-determination means that participants' values and decisions should be respected (Flick 2015:32). Full disclosure means that participants should be informed of any potential risks, benefits, or discomfort that might arise because of participating in the study (Cronin et al 2015:100). According to Cronin et al (2015:108), research participants have the right to choose voluntarily whether to participate in a study, and researchers are bound to respect participants' choices. Cronin et al (2015:108) assert that informed consent is central to the principle of autonomy in research.

Informed consent, according to Flick (2015:32), means that research participants have been given adequate information about the study, and that they have understood the information and have voluntarily decided to participate. Melia (2014:118) states that participants should be made aware of both the positive and the negative implications of participating in the study, as well as the risks involved. The same author emphasises that participation must always be voluntary. Participants were provided with information sheets (see Annexure 5) that contained adequate information about the study, and the principle of autonomy was fully respected. Since the method of data collection was focus group interviews, participants were told that the researcher could not guarantee full confidentiality, but participants were assured that their right to privacy and confidentiality would always be respected. By signing the informed consent form, all participants agreed to maintain confidentiality regarding what was discussed in the focus group interviews (that is, the information regarding who participated and what was discussed). The assistant moderator and the co-coder also signed confidentiality binding forms (see Annexure 8 and Annexure 9, respectively). Participants were informed of the researcher's plan to publish and disseminate the research results while maintaining participants' confidentiality and anonymity. Time was given for participants to think about the information about the study and ask questions before deciding whether to participate in the study. Consent forms to sign were only given to those willing to participate.

2.7.2.2 Beneficence

The principle of beneficence refers to always acting in the best interest of the research participants (Cronin et al 2015:109). According to Flick (2015:32), research that involves human participants should not be done merely for the sake of doing research; rather, it should have some identifiable benefits. It was foreseen that this study would improve the clinical learning experiences of nursing students The identification of gaps in the literature further justified the study. The students were very keen to share their clinical learning experiences, and they were positive that better clinical placement support for them and for future nursing students may result from the study. They were also keen to express their support needs.

2.7.2.3 Justice

Justice in research refers to equity and fairness in both research participation and the treatment of participants during the research study (Cronin et al 2015:111). Justice was ensured in all stages of the research study. When planning the study, the researcher first considered the potential benefits and the negative implications of participating in the research study. This study is the first of its kind to be carried out in Rwanda with nursing students regarding their support needs in clinical settings in Rwanda. Expressing their experiences gave the nursing students some sense of worth and recognition. Participants' questions and concerns were all attended to before, during, and after the focus group interviews. The researcher acknowledged and bracketed all her potential biases. Trustworthiness was enhanced through the use of direct quotations and member checking.

The focus group interviews were conducted in quiet conference halls behind closed doors, to protect participants' privacy. Anonymity and confidentiality were ensured in all reports of the study findings.

2.8 SUMMARY

Chapter 2 discussed the boundaries that were set for the study, through sampling, recruiting participants, conducting the focus group interviews, documenting the data collection process, and elucidating the data analysis process. The research methods and methodology were discussed in detail. This was followed by an explanation of the measures taken to ensure trustworthiness, ethical considerations, and ethical principles that were adhered to in the study. Chapter 3 discusses the findings of the study from an analysis of the data that was collected through the five focus group interviews.

CHAPTER 3

PRESENTATION OF THE FINDINGS

3.1 INTRODUCTION

In Chapter 2, the research methodology used in this study was explained. Chapter 3 discusses the findings from the data that was collected through five focus group interviews and handwritten field notes. The demographic profile of the participants is provided, followed by an elucidation of the themes, categories, and subcategories that emerged from the data. The coded data is supported by verbatim transcripts from audio recordings of the focus group interviews. Where codes are provided, the number of the focus group and the participant number of the focus group where the quotation appears are used to reference the quotes. For example, focus group 2 participant 4 is represented as “2:4”. The participants were assigned numbers during each focus group, to provide structure during transcription and facilitate understanding of the data by the researcher.

3.2 FINDINGS

3.2.1 Biographical data

Data collection was done in conference halls of one campus (Remera Campus) of the College of Medicine and Health Sciences of the selected university, located in Gasabo District of the city of Kigali. All participants were second-year to fourth-year students registered for a four-year undergraduate course leading to graduation as A0 nurses (nurses trained at the bachelor’s degree level). A total of 35 participants were included in five focus group interviews. Some participants were self-funded, and others were state-funded (dependent on government bursaries). Although the plan initially was to include first-year students, they were not part of the actual study, because their clinical placement was interrupted by Covid-19 restrictions, and they therefore had no clinical placement experience to share. All participants were between the ages of 20 and 25 years, where the average age was 22 years. Eighteen (51%) of the participants were female, and 17 (49%) were male. Focus group interviews 1, 2 and 3 were homogeneous (made up of participants from the same year of study), and the last two focus group interviews were

heterogeneous (a mix of all the years of study). The constitution of the focus group interviews allowed some flexibility in terms of gaining insight into student support needs by year of study. However, the researcher was interested in gaining a comprehensive picture of nursing student support needs during clinical placement. This study is the first study on this topic to be carried out in Rwanda. Numbers were randomly assigned to all participants in each focus group, and the numbers reflect the total number of participants per focus group. For example, focus group 1 had eight participants. Therefore, it was composed of participant 1 up to participant 8. For purposes of illustration, participant 7 in focus group 1 will therefore be referenced as "1:7". Each participant mentioned their number every time before speaking. The participant number was in no way linked to the participant's name or any identifiable attributes. Table 3.1 below indicates the composition of each focus group.

Table 3.1 Biographical information summary

Focus group number	**Focus group 1**	**Focus group 2**	**Focus group 3**	**Focus group 4**	**Focus group 5**
Number of participants	8	8	6	6	7
Age range in years	23–24	22–24	20–24	21–25	20–25
Gender	Male=5 Female=3	Male=4 Female=4	Male=2 Female=4	Male=3 Female=3	Male=3 Female=4
Year of study	Year two=0 Year three=0 Year four=8	Year two=0 Year three=8 Year four=0	Year two=6 Year three=0 Year four=0	Year two=0 Year three=4 Year four=2	Year two=2 Year three=3 Year four=2
Focus group interview constitution	Homogeneous	Homogeneous	Homogeneous	Heterogenous	Heterogeneous

3.2.2 Thematic data

Themes, categories, and subcategories emerged from the data. The data describes the learning experiences of nursing students registered for an undergraduate nursing programme at a selected university in Rwanda. The data highlights, firstly, the support needed for clinical facilitation and, secondly, suggestions to enhance clinical learning from the clinical learning experiences of nursing students registered for an undergraduate programme at a selected university in Rwanda. The students shared their clinical learning experiences, while focusing on their clinical learning needs and how their clinical

placement can be enhanced. Therefore, objectives 1 and 2 are addressed in an integrated discussion.

Themes, categories, and subcategories that emerged from the data are discussed in the following section and are depicted in Table 3.2 below.

Table 3.2 Themes, categories, and subcategories

Theme	Category	Subcategory
1 Support needed, identified from students' clinical learning experiences.	1.1 Support during clinical placement	1.1.1 Financial support: The need for a clinical placement allowance
		1.1.2 Emotional support: The need for counselling services and respect towards students
	1.2 Teaching and learning support	1.2.1 Supervision support
		1.2.2 A solid/concrete agreement between the university and clinical site management
		1.2.3 Not meeting learning objectives
2 Suggestions to enhance clinical learning during clinical placement	2.1 Teaching and learning approach	2.1.1 Suggestions for assessments
		2.1.2 Suggestions for clinical site nurses
		2.1.3 Suggestions for supervision
	2.2 Suggestions related to planning of clinical placement	2.2.1 Timing of clinical placements
		2.2.2 Organisation of clinical placements
	2.3 Suggestions to improve communication	-

3.3 THEME 1: SUPPORT NEEDED, IDENTIFIED FROM STUDENTS' CLINICAL LEARNING EXPERIENCES

According to Joolaee et al (2016:5), support means receiving help to develop to become a competent nurse. Lekalakala-Mokgele and Caka (2015:9) state that the overall quality of education of nurses depends heavily on the quality of clinical teaching and learning, which can be achieved through effective clinical facilitation and support (McAvoy & Waite

2019:20). It was evident from the discussions that participants were aware that effective student support was necessary to enhance their clinical learning experiences. They expressed a feeling of relief as they mentioned the support needed to enhance their clinical learning experiences. They were aware of the need to practise procedures repeatedly under close supervision to improve their ability to care for patients in real life. They expressed gratitude for the opportunity the study afforded them to articulate their support needs. One participant verbalised gratitude as follows:

> "Special thank you to the organisers of this research because it came at a time when there are some challenges. I was desperately looking for a platform to raise this." (5:2)

Categories under this theme are support during clinical placement and teaching and learning support.

3.3.1 Support during clinical placement

Participants viewed support as a very important aspect of their clinical placement. They said going on clinical placement was like starting a new life. They expressed a feeling of being overwhelmed by the financial and emotional needs that clinical placement placed on them. They mentioned that support was very much needed for them to overcome their financial burden and to boost their self-esteem. The majority of the participants expressed a feeling of stress, as they said that they leave their campus, where they have accommodation they are paying for, and move to another place to find new accommodation, and that they have to transport their household items. Van der Riet, Levett-Jones and Courtney-Pratt (2018:45) explain that clinical placement sites that are near to the university are advantageous to nursing students. Participants mentioned that travelling to a distant location was stressful, and that it placed a huge burden on them. Some participants expressed this as follows:

> "Then you migrate, like, two … you cross, like, two provinces and find another house. Is so stressful and so hard. It is your first time to reach there. You don't know anyone there, and you have to rent a house. You have to start, like, a new life. And unfortunately, you are left with nothing. How're you going to start a new life in the Nyagatare District?" (5:2)

> "It takes us to pay for our luggages, the transport, even transporting our materials to the clinical site. So we are paying this money, and it is hard for us to get it, for sure. So it's affects us so much, in different ways." (2:3)

Some participants mentioned that the difference in cost between different placement sites places a heavy burden on students who depend solely on student bursaries. One participant articulated this as follows:

> "Some students are taken to Northern Province at Byumba Hospital, or in Kigali. To live there the cost is different, even the house for rent they are totally different, while there is no extra money given to the students for clinical placement. Students who only depend on bursary they get the challenge when they get there in clinical placement." (2:4)

The majority of the participants expressed feelings of emotional vulnerability, as they articulated the need for emotional support during clinical placement. They said that sometimes they are exposed to traumatising situations that need specialist intervention, but that most of the time they find no one to talk to. The participants expressed emotional support needs in terms of depressing events, self-worth, and lack of respect and advocacy from nurses. The subcategories under this category are financial support and emotional support.

3.3.1.1 Financial support: The need for a clinical placement allowance

The need for a clinical placement allowance was evident during the discussions with participants. Participants reported a need for the government to reinstitute the award of a clinical placement allowance to nursing students. One participant expressed this as follows:

> "There is kind of money (I don't know the name to call it) that students were being paid before per day when we were in clinical placement, but these days that money has been stopped. There is no longer given to the students, and so far the lives of students there in clinical placement has been affected so much after removing this money." (2:3)

Participants voiced concerns about the timing of the award of bursaries and the lack of consideration of the differences in the financial costs of different academic programmes, as the same bursary amount is awarded to all students irrespective of what degree they are studying. They expressed feelings of disappointment, as they said that the bursaries are disbursed late and that the university does not consider the timing when planning their placements. Participants commented that the same bursary amount is given to all students who benefit from a student bursary. However, the financial needs of nursing students are different from those of their counterparts studying other courses, which do not require clinical placement. Some participants articulated this as follows:

> "I can say you how this came, how they give out bursary. They give it out in bad way. And students we were going through hardships because of the timing of it." (5:2)

> "When we get delayed to the money that is supposed to support us in the training, sometimes we work with hunger. So, we need to get living allowance on time. Then we can go in training and fulfil our objectives properly." (1:8)

> "All of us as students who study on loan we have seen same fees, same living allowance, but we study in different ways, you see. We start migrating from level 1." (5:6)

Participants expressed feelings of financial distress, as they reported that they incur additional expenses, including transportation, accommodation, and food. Some participants said that at clinical placement sites, they find accommodation that is far from the health facilities. Some mentioned that sometimes due to hunger, they miss hours or even days at the clinical placement sites, and that some landlords evict them from their accommodation. Some participants expressed this as follows:

> "Sometimes we work with hunger. Then in the afternoon we don't go [back] there, because we don't have strength to go there." (1:8)

> "Goes to the hospital with having hunger, and to give care to the patients it is too difficult. Is not good to them. We face the problem with lacking the ghettos [accommodation]." (2:2)

> "Sometimes the students they don't go to the clinical placement, because some they are hungry, or they have faced challenges where the landlords have chase them out." (4:6)

Some participants articulated that financial constraints limit them from exploring their full potential, such as reaching out to the interior rural communities to attend to community diagnosis, which requires home visits and health education. One participant shared that during one of their clinical placements, they were limited by financial constraints from carrying out home visits to children who needed special intervention:

> "Last weeks we were in a training on the field. We had a child who had malnutrition in society. So we have the duty to reach each one. They were 20! We didn't have transport to go there. There were some mountains, so the health centre said, 'We don't have transport to go there,' to reach those children." (1:8)

3.3.1.2 Emotional support: The need for counselling services and respect towards students

The clinical learning environment is dynamic and complex. The nature of its context and the relationships between key stakeholders are bound to influence clinical learning experiences. It was evident during the discussions that the participants needed someone during clinical placement to whom they could communicate their anxieties and fears, to improve their ability to cope with the stressors of clinical placement. Participants mentioned that the lack of a process where they can communicate their emotional needs, such as counselling services during clinical placement, gave them a feeling of lack of resilience and optimism.

They commented that their clinical experience and their personal sense of worth were negatively impacted whenever they experienced anxiety-provoking and depressing events. They reported that prior to clinical placement they receive orientation from their school about what placement is all about. However, when they experience or see certain depressing situations during clinical placement, they find no one to talk to, which gave them a feeling of lack of assurance, lack of care, and lack of empathy shown towards them. Participants said that they felt emotionally vulnerable, uncomfortable, and stressed.

Some participants said that the lack of emotional support made them think of dropping out of a career in nursing. Some participants verbalised this as follows:

> "They don't give us some information [like] how we are, what we are going through. I feel like we need counselling in clinical placement, because we face some problems. Some they go stressed and got desired for what they see. Some they feel like to drop down the nursing and go to other facilities. So we, like, need counselling." (3:3)

> "When I was in level 1, I thought, like, I want to leave nursing career when I was in that hospital. So that discouraged me. It made to me, like, feeling uncomfortable and start thinking, like, nursing is not good." (5:6)

It was evident from the discussions that participants needed their abilities, feelings, and rights to be given due regard during clinical placement. Participants were aware of their commitment to the ethical principle of respect for humans. They said that showing respect and value towards students was necessary for them to feel safe, to build trusting relationships, and to communicate effectively. Participants expressed feelings of powerlessness and disappointment when they verbalised the failure of nurses and supervisors to show them respect and advocate for them when patients expressed mistrust towards them.

The majority of the participants reported that they experienced a problem of low self-esteem, due to lack of respect and value towards them from healthcare providers, supervisors, and sometimes patients. They said that the lack of respect is demonstrated through their being corrected harshly, through nurses with a lower level of education having an inferiority complex, through mistrust from patients, and through clinical practice stereotypes. Some participants commented that their level of confidence was affected, and they perceived that they lacked adequate experience, which made them scared of performing some procedures. Participants said that they felt some nurses showed a clear disregard for whether they are able to perform procedures the way they have learnt, while other nurses and some supervisors disregarded their feelings and spoke to them rudely when correcting or teaching them.

Regarding the patients, some participants reported that some patients do not find worth in the care provided by students, as they fear that they will be poorly managed, which was mostly demonstrated by their refusal to be touched by students. The majority of the participants reported that the harsh way nurses and supervisors corrected students in front of patients created mistrust between patients and students. They reported that mistrust between patients and students is more common in urban areas than in rural areas. Participants said that if nurses could advocate for students in front of patients, it would make things better. They mentioned that their self-esteem was greatly impacted. The majority of the participants said that students' procedures and practices could be supervised, so that patients can feel safer. Van der Riet et al (2018:45) found that developing relationships with staff during clinical placement led to students feeling a sense of belongingness and social connection, and feeling welcome. They reported that students felt more confident in the presence of a supervisor. Hoffman and Daniels (2020:9) found that self-directed learning was encouraged to enhance students' confidence and reduce feelings of anxiety; however, independent practice was allowed after practice under guidance. Some participants expressed this as follows:

> "If the value given to the student in clinical setting by health providers may be enhanced, could be better than before. […] Students are not being valued as it should be. We wish to build our self-esteem in what we do. He or she doesn't take time to tell you, 'You have to do it like this or like that.' Another time you are going to perform that activity, you will be afraid to do it." (5:1)

> "And when he comes, he is, like some of them. They're not all … He comes, like, blaming students. He comes, like, unfriendly. He comes, like, harassing, instead of teaching. Some of the supervisors they are like that." (5:2)

The way participants were corrected was viewed by them as negative feedback that undermined their feelings and their self-esteem:

> "Patients used to neglect many students and say, 'You can't touch on me. You may not manage us well and make us very ashamed [embarrassed].'" (2:2)

> "Many patients did not allow the student to care for them. They fear us, and they say we are not skilled well in some of them and refused to be cared by the interns." (3:6)

Participants commented that the relationships between students, nurses, and supervisors depended on individual personalities. They said that nurses with goodwill developed a good relationship with students.

3.3.2 Teaching and learning support

Fagan, Lea and Parker (2021:445) hold that clinical education providers should act out behaviour that demonstrates a non-judgemental attitude, to facilitate a clinical learning environment that is supportive of engaging and safe conversation with students. Teaching and learning support was viewed by participants as assistance with their learning activities offered during clinical placement. Gusar, Bačkov, Tokić, Dželalija and Lovrić (2020:28) state that the supervision approach and the supervisor-student relationship are important factors that determine nursing students' satisfaction with their clinical learning.

Participants mentioned that their expectations for teaching and learning support were for healthcare providers at the clinical facilities and the supervisors from the nursing school to work in collaboration with each other to create a safe and caring clinical learning environment that can help students achieve their learning objectives. They said that collaboration was necessary to foster a sense of belongingness.

The teaching and learning experiences shared related to the teaching guiding support they received from their supervisors, clinical site nurses, medical doctors, and other healthcare personnel in the health facilities where they were placed for clinical practice. It was evident from the discussions with the participants that they have had both positive and negative experiences regarding teaching and learning support. One participant expressed satisfaction with the clinical teaching and learning. However, the majority of the participants expressed dissatisfaction with the teaching and learning support, as it was evident from the discussions that they felt neglected most of the time. They said the lack of support slowed down acquisition of new knowledge and skills, because lack of close supervision resulted in repetition of mistakes and practising by trial and error. Some participants articulated this as follows:

> "One it was to Nyagatare Hospital. Other one hospital it was in health centre at Gahini. All of them has been best for me, yeah, for even safety was good, and I

met many challenges there, because it was the first time. But according to the objectives we [were] given, all of them … I think all of them … almost—" (5:1)

"There was little number of nurses, and even the supervisors could come after two weeks. Sometimes I face serious challenge and I could run to find someone to help me, and I could probably find everyone busy. Like, those nurses are very few, and I could just do whatever comes so as to save the client." (3:4)

"Our supervisors can come, like, once in the whole period of clinical placement, and that is not a good way to supervise us." (1:2)

"So they did their work, and they don't help us." (5:3)

3.3.2.1 Supervision support

Supervision support is necessary for the development of students' cognitive, affective, and psychomotor support, as well as their emotional support, during work-integrated learning (Hoffman & Daniels 2020:2). According to Girija (2012:25), clinical supervision is a prerequisite for safe patient care and effective clinical learning. Supervision was viewed by participants as a guarantee for students to learn new information, safely practise what they have learnt in theory, and gain experience. The majority of the participants reported that they did not get sufficient supervision, and it was evident that they questioned patients' safety. In a study conducted by Fagan et al (2021:447), they found that students' behaviour of speaking up about patients' safety was influenced by the chance of harm to themselves and to patients. They explained that students experienced speaking up as challenging, as they feared being belittled, ignored, and ostracised. One participant verbalised this as follows:

"Imagine sometimes I was placed in condition where I was, like, the master of all the things. I have a patient in front of me. I must do whatever. I must, yes, practise what I learnt in theory. I could just do whatever comes so as to save the client, but still it becomes problem to get experience. So supervision is still the problem. We need more supervision, so as to get more information, so as to practise. Even [though] we study theory, we need also practice." (3:4)

Participants reported that they received supervision from nurses, supervisors from their university, and other healthcare personnel, but that the frequency and the quality of the supervision were problematic. They said that the infrequency of the supervision was due to there being few supervisors, low staffing at clinical sites, conflicting priorities, and reluctance among some healthcare providers to support nursing students. Girija (2012:25) argues that an acceptable student-supervisor ratio is 6:1. In a study conducted by Hoffman and Daniels (2020:11), a student-supervisor ratio of 24:1 was viewed as a challenge that hindered supervisors from providing adequate support to students during clinical placement. Some participants verbalised this as follows:

> "They don't have time for students, because they want to complete, or to finish, their work before next shift." (2:7)

> "You can find that about 20 students are having only one supervisor." (1:4)

> "The nurses are very few, and the patients are many. So due to the shortage of nurses, the nurses have much responsibility." (3:6)

> "Sometimes supervisors may come to the site, like, once in a whole month, and the goal that makes him more hard to come is mainly doing the evaluation and saying goodbye." (3:4)

> "Other healthcare providers, including medical doctors, neglect nursing students, most of them, because when you ask him or her some question regarding some pathology or something, and he tell you to ask from your fellow nurses." (2:6)

It was evident from the discussions with participants that they identified some deficiencies in the knowledge and skills of some nurses and supervisors assigned to them. They expressed doubts regarding nurses' awareness of the scope of nursing practice. Participants commented that the problem with quality was due to knowledge and skills inadequacies in some nurses/supervisors, failure by some supervisors to respect supervision guidelines, a language barrier for some nurses, and some supervisors being assigned tasks beyond their area of specialisation. Hoffman and Daniels (2020:1) assert that teaching and learning during clinical placement can be negatively affected by having inadequately prepared clinical supervisors, which can result in an inability to effectively integrate theory and practice. Participants reported that some nurses were willing to teach

students, but that they were deficient in the knowledge and skills to do so, while other nurses had the knowledge and skills but lacked the passion to teach. One participant articulated this as follows:

> "Some of nurses over there they are having, of course, the skills to teach, but they don't have that kind of vocation, or passion, to do it. Because teaching and helping someone to learn from you it requires that passion." (3:3)

Participants mentioned that a knowledge and skills gap was evident in supervisors when they were asked to supervise students at a level that they had not taught when they were in nursing school, or when they were assigned to supervise students in a specialty that was not their field of specialisation. One participant verbalised this as follows:

> "We are in mental health department. We went in internship to fulfil learning objective of mental health. Our supervisors he or she studied midwifery, for example, and he comes to supervise you. When he supervises you in mental, there is some gap when you ask them about some challenges you got in this hospital, or with a patient. Then you ask him about a question you got there, and he doesn't respond you." (1:8)

Some participants reported that there were instances where some supervisors told students to perform procedures differently from how they had been taught, so that they could learn how to manage time. They mentioned that they perceived a theory-practice gap, and they expressed fear of being incompetent, and fear of being unable to meet the pre-registration requirements during board examinations. One participant articulated this as follows:

> "Where the students attempt to follow the guidelines according to the evaluation form, but lecturers tell him to perform the procedures without asking consent to the patients [and] without assessing him, for instance. He tells you, 'Do the procedure.' We see that as challenge, because that evaluation also is respected during the council examination." (2:4)

Participants commented that nurses at health facilities communicate in French, while the students' language of instruction is English. So, the students spent time trying to translate

or understand what they were taught by those nurses. One participant verbalised this as follows:

> “In theory [in the theory component of the course] we use English, and when we reach there we find that those nurses who are there working they use French, and we get the challenge with language and time of getting knowledge. The nurses come there, explain for you. Like, translating in English become a problem.” (3:5)

Girija (2012:26) asserts that the core skill of clinical supervisors is their ability to structure the learning activities and the learning environment. The majority of the fourth-year students mentioned that they preferred to have mentoring more than supervision, and they said they preferred structured learning activities that actively engaged students. Mentorship in clinical nursing education is flawed, in that it lacks a universal approach. In a study by Gusar et al (2020:28), they identified the mentorship approach and mentor-student relationships as important factors that determined nursing students’ satisfaction with their clinical learning. Mentorship was viewed by participants as the best way to facilitate their transition from student to the role of nurse. Thomson, Docherty and Duffy (2017:517) found that students in their final clinical placement felt the need to be less reliant on their mentors, and that they prioritised independent practice and using their own initiative. In this regard, some participants shared the following:

> “They can use reports. They can make a group discussion at the end of, like, two days in a week. They could try to structure.” (1:7)

> “We go there and we find they give us supervisors, and I would like to say that we students we need to mentorship more than supervision. When you mentor student, you provide him or her skills and practices that can help him or her to improve in learning profession.” (4:6)

Participants reported that nurses with a lower level of education were less likely to provide support to students studying at the bachelor’s degree level, due to them having an inferiority complex. In terms of experience, they mentioned that nurses with less than five years’ experience were more willing to offer support to students than nurses with more than five years’ experience. Some participants expressed this as follows:

> "If they get to know that you're in bachelor's programme, I think it's too complex, because most of the nurses they have advanced diploma, and they feel like when you finish, you are going to have a degree that is above them." (5:6)

> "Those who like to teach are the ones who have one year of experience at hospital, but those ones who have, like, seven to ten years are not willing to teach." (2:4)

Participants reported that the organisation of the clinical placement site played an important role in their learning. They said they were likely to learn more and achieve their learning objectives at better-organised placement sites, and that the presence of a clinical facilitator enhanced their learning. Drennan (2002:475) found that a clinical placement coordinator was seen as a positive addition to the student support team, as the clinical placement coordinator was responsible for student support and practice development, although the role was criticised for role confusion, which was identified by some clinical education providers. One participant verbalised this as follows:

> "I found some district hospital someone who is in charge of students who are in internship, where he manages all challenge or anything the students do, for the students' well-functioning of our internship." (2:3)

Participants raised concerns about the manner of supervision. They reported that some supervisors come to clinical placement mainly to find out if students have been attending placement, or for evaluation and signing of papers. In their study, Hoffman and Daniels (2020:6) identify the importance of role orientation in helping clinical supervisors adjust to their role of clinical supervision. They explain that a clinical supervisor's qualifications as a registered nurse are often assumed to suggest that they are adept at performing clinical teaching, which allows clinical supervisors to draw on their individual and professional experiences to guide their teaching. Some participants verbalised this as follows:

> "There are others who always come. It's like they bring you papers to sign for them and just … they leave. You sign papers of, like, the whole period. Why he didn't read?" (5:6)

> "Most of our supervisors are like, 'When did you get to the hospital? When did you leave? Have you been there?' Things like that." (1:7)

> "Imagine a supervisor might come once in the whole clinical placement period, most of the time on evaluation day. And he wants you to maximise. How can you maximise? You didn't find anyone to help you achieve your objectives." (5:2)

3.3.2.2 A solid/concrete agreement between the university and clinical site management

Van der Riet et al (2018:42) found that a collaborative clinical placement model grounded by a tripartite relation between students, university staff, and clinical partners led to students receiving support from everyone in the clinical learning environment. The participants in this study reported that the majority of nurses and other healthcare providers at the clinical sites do not feel obligated to provide support to students. They said that due to there being few supervisors, nursing students spend most of their time during clinical placement with clinical site nurses and other healthcare providers. However, participants commented that most of the nurses neglect teaching students, due to either conflicting priorities, their having an inferiority complex, or their not feeling obligated to teach students. Participants mentioned that most of the time students seek someone with goodwill to teach them. They said that most of the time the nurses are challenged with a heavy workload, due to staffing constraints. It was evident that students who lack self-motivation are likely to achieve less. Participants commented that sometimes they collaborate with their peers to learn. However, they said that an inferiority complex exists among students registered for the A1 (advanced diploma) programme and the A0 (bachelor's degree) programme, which hinders collaboration:

> "Some nurses in the hospital are not ready to teach the students, where we find some nurses are not collaborating with the students. They came to job. No other things, no teaching, no what. But few of them are good and would like to teach." (2:4)

> "There are shortage of nurses who come to explain something, and we are likely to find something for us instead for being taught." (3:1)

> "They are ready for more activities for, like, nurses, and they don't have time for students." (2:7)

> "Once you meet, like, students from advanced diploma at the same hospital, it's like checking … always checking … checking whether you made an error." (5:6)

3.3.2.3 Not meeting learning objectives

Participants reported that they usually go to clinical placement with defined expected goals from their university, called clinical learning objectives. They said that these learning objectives are supposed to guide the facilitators of their clinical placement on the required skills and knowledge that students are expected to achieve by the end of each clinical placement. However, the majority of the participants commented that most of the time they do not reach their goals. They said that several factors contributed to their inability to achieve their learning objectives. They mentioned that the reasons their clinical learning objectives were not met were a mismatch between the placement site and the set learning objectives, overcrowding at the placement sites, short placement time, work overload, unfavourable clinical placement sites, and lack of follow-up on the learning outcomes, or lack of systems for measuring if the learning objectives have been met.

Participants commented that sometimes they are given learning objectives that cannot be achieved at the clinical site where they are placed, because the site is not suitable in terms of procedures that can be performed there. They also mentioned that sometimes they are given learning objectives that do not match their level of competency. In this regard, some participants shared the following:

> "They give us clinical placement in the health centre. Then they set up a consultation room, for sure. We didn't have that skill to do it. Many of us spent like a month on restriction, because no knowledge to using consultation." (3:2)

> "We have objectives of caring of someone who has colostomy or assist other surgeries, like in general surgeries. They are not available there in district hospital, never available, because those cases are not able to be performed there. And you have those objectives." (2:6)

Participants commented that sometimes they met students from other universities at different academic levels and with different objectives, and that it became difficult to distinguish the different expectations:

> "Sometimes you meet student nurses from many schools. And it's, like, you miss someone who instruct you, because most they are in different years. So, when you want to learn new things, you lose, like, someone who can … It's like they told us we have … 'You have to arrange yourself,' so that you can know, like, someone who can support you." (5:6)

Some participants reported that some clinical placement sites are not suitable for students, because they are very far and inaccessible. They said that getting to those sites is very difficult for students, supervisors, and even patients. Participants mentioned that they are less likely to achieve their clinical learning objectives at those sites due to lack of cases:

> "Some clinical sites are not favourable to us as students, even the teachers, because some of them are far and the transport is too difficult to reach there. Some clinical sites are in the rural areas, and getting the bus or motorcycle are difficult, so reaching there is problem. Even the patients are not available to that site." (2:5)

Participants mentioned that most of the time there is a lack of follow-up on the achievement of clinical learning objectives. They said that at the beginning of clinical placement, they hand over their learning objectives to the nurses in charge of their learning, but that in practice the learning objectives are not followed:

> "We give them specific goals, and they see them before we start our clinical placement. But in practice they don't obey it. I was in the hospital in Kigali, and they ask me to do venipuncture. I was still in level 1. I didn't have information about it. I can't say, 'I don't do it, nurse.' Can say that I am disrespecting her. I do it with few knowledge." (3:2)

3.4 THEME 2: SUGGESTIONS TO ENHANCE CLINICAL LEARNING DURING CLINICAL PLACEMENT

Clinical learning was viewed as a very important part of clinical placement. Participants were aware that clinical learning was vital for them to apply theoretical knowledge and develop clinical skills to become competent professionals. They shared their clinical learning experiences and proposed, from their own perspective, what they thought could be done to enhance clinical facilitation, to give them enhanced clinical learning

experiences. Participants expressed feelings of optimism as they voiced their expectations from the university management, supervisors, clinical site nurses, patients, and other healthcare providers. The categories under this theme are suggestions related to teaching and learning, suggestions related to support needed, suggestions related to planning of clinical placement, and suggestions related to communication.

3.4.1 Teaching and learning approach

Participants reported that there was a need to optimise the way they acquire knowledge during clinical practice, to ensure that they become competent professionals. They shared their views regarding what can be done to ensure proper acquisition of clinical skills in the clinical setting. The views shared are in terms of evaluation (assessment), clinical site nurses, and supervision.

3.4.1.1 Suggestions for assessments

It was evident that participants needed improved formative assessment, formative evaluation, summative assessment, and formative feedback. These concepts were all referred to as “evaluation” by the participants. Participants expressed dissatisfaction with the way they are assessed and evaluated in clinical settings. The majority of the participants reported that they do not get assessed in all departments. They said that evaluation is sometimes inconsistent, unsatisfactory, and insufficient. They suggested that evaluation be consistent and aligned with learning outcomes, that evaluators be supervised to ensure that they follow evaluation guidelines, and that timely feedback be provided to students after assessment/evaluation. In this regard, some participants shared the following:

> “But at the end you find a less percentages is achieved, and if you reflect, you see that you did an evaluation examination when the examination from year 1, year 2, year 3, and year 4, for example, one dressing. So, there should be a follow-up of how those objectives are achieved, and if there is no achievement, how they can assess … do the assessment to see what is missing, to meet those objectives.” (4:6)

> "If you get many evaluations, like in a two-months period, and most of us don't get even one at the end of the clinical placement. And I think the evaluation should be very strict and should be carried out multiple times, like three times in a week. That could push the students to learn more and show what they learnt. If we have an evaluation on every department we are in, it will really enhance what we catch." (1:7)

> "Having the evaluation at the end of clinical placement didn't support us well. So, if we have an evaluation on every department we are in, it will really enhance what we catch." (1:6)

> "So, there is a form called evaluation form that contains the guidelines to the evaluation. Some nursing students become evaluator-aware about that form. So, it become standard, so that students have the same standard without depending to the evaluator." (2:5)

3.4.1.2 Suggestions for clinical site nurses

It was evident from the discussion with participants that they spend most of their time during clinical placement with clinical site nurses. The majority of the participants commented that they receive most of their support from clinical site nurses. They proposed some suggestions regarding what can be done to enhance the support that clinical nurses provide to them during clinical placement. Participants suggested more training for nurses. They suggested that nurses' ability to teach students could be improved through providing in-service training to nurses on educating students. They said that some nurses are willing to teach students, but that they lack teaching skills, or they teach procedures in different ways. Training of nurses was viewed as a facilitating factor to improve interpersonal relationships between nurses and students:

> "So, the training is more important, because their techniques are totally different. So, I would like to tell you that if they are trained and we use the same technical, will be good, and we will be able to follow that technique as they teach us. You see, the nurses who finished to study many years ago they technically different." (2:8)

> "Nurses over there should be trained to have this ability … capacity to help the students learn." (2:3)

Hoffman and Daniels (2020:11) identified training needs for clinical supervisors, and they suggested continuous in-service training and workshops for the development of clinical supervisors' skills.

3.4.1.3 Suggestions for supervision

It was evident from the discussions with participants that they viewed quality and quantity of supervision as an important aspect of support that should be enhanced, to enhance their clinical teaching and learning. They said supervision was important to ensure that they follow the set learning objectives and achieve the desired learning outcomes. Participants suggested that supervision be improved in terms of both quality and quantity for students to achieve their learning objectives. One participant shared as follows in this regard:

> "The organisation to make supervision to the student going to clinical practice has to be improved, and to make sure the student are fulfilling their objectives." (1:1)

Participants suggested that the number of supervisors be increased, to increase the frequency of supervision. One participant shared as follows:

> "It is a suggestion, a strong one, that supervision would be increased at the high level … at the high level, such that each student would have someone to help him or her … to assist him or her in every kind of new performance that he or she does, because it is very challenging." (3:4)

It was evident that participants needed an evaluation of the quality of their supervision. Some participants reported that some supervisors ignore the evaluation guidelines and ask students to perform procedures in routine ways. Participants suggested that guidelines for supervision be provided to supervisors, and that implementation of the guidelines be enforced. In this regard, some participants shared as follows:

> "What I really need so that we can enhance in clinical placement is that they can set guidelines for our supervisors." (1:6)

> "We need to provide the scope of nursing practices, because here in Rwanda we don't have the scope of nursing practices. If they have it, they do not implement it." (4:5)

Some participants suggested that more mentorships should be provided to students, and that time to have discussions with peers and supervisors should be made available to students during clinical practice. Some participants shared as follows:

> "To provide student nurses a mentorship and time to discuss what they learnt and to do a follow-up." (4:6)

> "So what I can request is maybe they can use the time so students can get more time to revise what they study in clinical placements, have the mentors to help them." (4:3)

Van der Riet et al (2018:45) found that placement sites that were near to the university afforded students the opportunity to have on-campus study groups, where peer support was realisable. Some participants suggested that if there is at least one clinical facilitator who is responsible for students at all clinical sites, their clinical placement could be enhanced. Some participants expressed this as follows:

> "As an advice, I would like for advocacy to put those in all DH [district hospitals] for the students' well-functioning our internship." (2:3)

> "There should be one staff member, or one worker, who is in charge of the students, in order to help those supervisors to reach the students." (1:2)

3.4.2 Suggestions related to planning of clinical placement

It was evident from the discussions with participants that there is a need to improve the planning of clinical placement. Participants made suggestions in terms of what they think can be done for prior and continuous planning of clinical placement. The subcategories under this category are timing of clinical placement and organisation of clinical placement.

3.4.2.1 Timing of clinical placement

Participants reported that they experienced some challenges during clinical placement related to poor timing. They mentioned that they experienced issues of overcrowding at clinical placement sites, short placement time, and variability in the academic calendar for the nursing programme.

Regarding overcrowding, participants commented that they met many students from other universities who were at different levels with different learning objectives. They said that the clinical placement sites became overcrowded and that the clinical site nurses had difficulty following the many students from different levels with different learning objectives. Participants said that many times they failed to achieve their learning objectives. They suggested that this could be solved if the universities collaborate with each other and with the clinical placement sites. They said collaboration could allow the universities effective communication with each other, so that students can be sent to clinical placements in shifts. One participant verbalised this as follows:

> "When one university plans to go in October, another university already knows that this university has students in this hospital. So we should postpone our clinical placement, to prevent a lot of students in one hospital. So it creates overcrowding at clinical site [and they] are not able to serve us all to help us achieve our objective." (1:8)

Regarding the duration of clinical placement, participants reported that each clinical placement had a short duration, which made them spend a relatively short period of time in each department. They commented that just as they started settling in after orientation in a department, it was already time to leave. Participants said that the management of time was ineffective, because they felt that they spent most of their time during clinical placements doing orientation, and that they did not have enough time to practise. They suggested that this could be solved by switching to a model of clinical placement where students spend one semester in the classroom and the following semester at the clinical site. Some participants expressed this as follows:

> "Because we have only two weeks, and on those two weeks, one is for orientation, other week we are making reports of that department. So that's the challenge we meet, and where we see we can't reach on our goal." (1:6)

> "When you went there for one month, you take one week for attention, and other second week you still just for you… or for you to feel that things are improving in, and you take two weeks for studying. It's not enough." (3:5)

> "If it possible, they can change the curriculum and they say, 'This semester is for clinical placement,' so we can have enough time to practise what we learn at school." (3:3)

Regarding variability in the academic calendar, participants mentioned that sometimes the academic calendar for the nursing programme is longer than that of the courses that their counterparts are studying. They said that this places an additional burden on nursing students, emotionally and financially. One participant verbalised this as follows:

> "Some of the students of University of Rwanda they have completed the year in June, others in July. I don't remember if it is September. Then the life become hard for students. You have just carried out, like, 11 months." (5:6)

3.4.2.2 Organisation of clinical placement

The need to enhance the organisation of clinical placement was evident from the discussions with participants. The majority of the participants commented that effective organisation before and during clinical placement was necessary to enhance clinical placement experience. Participants suggested that if the university could do an assessment of the clinical placement sites to establish whether they are suitable for their objectives in terms of material resources, personnel, and accessibility, clinical placement time could be spent more effectively than before. Some participants expressed this as follows:

> "The first thing is to always evaluate clinics we are going to spend our time in, and should always evaluate them to see if we can meet our objectives there, before we go there." (1:7)

> “Last placement we attended the lecturer was calling us that he lost bus for coming, as the bus that was coming in that rural area was one. They were waiting for that bus at station bus, and he said the bus was gone. And when the bus was gone, you wait the … for another day.” (2:5)

> “Some of the clinical learning outcomes we are given they are so high compared to the institutions we go in for clinical placements.” (5:7)

> “Sometimes they send to a countryside, far away from their campus. So, we find that it is even harder to accommodate, and you cannot even meet a supervisor for at least once a month. So, if you meet some problems, your safety it … and robbery there, you have no one to talk to.” (4:6)

It was evident from the discussions with participants that they prefer that their financial ability and preferences be considered when clinical placement sites are chosen for them. One participant verbalised this as follows:

> “Just for the preparation at the school, I think, is to ask the student if they ready to go in the clinical placement, and see what they miss, like we used to need the mask and the other uniforms, and see if we are well prepared in time of going there, so that we can do … or face the problem, like, of finding where to live, as we faced already … like, usual [usually] in those things. I think they can think about it.” (3:5)

One participant reported that sometimes some students do not get a clinical placement at a referral hospital throughout their four years of training. Participants mentioned that clinical placement at a referral hospital is essential for students to learn the skills of specialised nursing care, such as mental health care and cancer care. They suggested that students could be placed at referral hospitals in shifts, to ensure that all students get at least one clinical placement at a referral hospital. One participant expressed this as follows:

> “So, we need to have all students to get into those referral hospitals. But there are some colleagues who didn’t get there. There could be shifted to clinical placement for that to be achieved.” (4:5)

3.4.3 Suggestions to improve communication

The need to improve communication was evident from the discussions with participants. Participants stated that effective communication was vital to enhance their learning. They reported that they felt there were communication deficiencies in the planning of clinical placements. They said that these deficiencies in communication were in terms of a language barrier and systemic communication between the university and clinical placement sites, and between the university and students.

Participants reported that a language barrier was evident between students and patients, and between nurses and students. They commented that the majority of the patients speak and understand only Kinyarwanda (their first language). However, they had difficulty communicating or translating information of medical interest, such as some pathologies and certain medical terms, to patients, because no medical dictionary existed with translations of medical terms into Kinyarwanda. Participants mentioned that they were challenged with the difficulty of writing in English what the patients told them in Kinyarwanda. They suggested that Kinyarwanda be incorporated into the curriculum, and that each student have a pocket dictionary to keep with them during clinical placement, which could enhance communication between students and patients. One participant verbalised this as follows:

> "There's some, like … some patient told me the problem that he has in our mother language, which … so it's difficult for us if our curriculum … or when you're going to there to the clinical placement, or so they can someone who will prepare the curriculum, they can add some disease. So, when you are doing assessments, it's become very difficult. And sometimes in our mother language that that can help us to achieve our goals in English." (3:1)

Participants commented that communication was also a problem with the nurses, because most of the nurses could only communicate in French, while the language of instruction at the university is English. They said that the challenge with the language barrier caused them to spend much time trying to translate what was being communicated.

In 2003, His Excellency President Paul Kagame, the president of Rwanda, made English an official language alongside the country's first languages, namely Kinyarwanda and French. Following this change, the language of instruction was changed from French to English in 2008. Nurses who received their training before 2008 were trained in French, and therefore are only able to communicate in French. One participant expressed this as follows:

> "In theory [in the theory component of our course] we use English, and when we reach there, we find that those nurses who are there and working they use French, and we get the challenge with language and time of getting knowledge. The nurses come there, explain for you. Like, translating in English become a problem. Is what I saw when we are there in clinical placement." (3:5)

Participants reported that there is poor communication between the university and the health facilities. They said that sometimes the health facilities are not informed, because the health facility managers seem surprised when the students arrive at some clinical placement sites, which makes the students feel unwelcome. Participants suggested that this could be resolved through collaboration and effective communication between the health facilities and the university. One participant verbalised this as follows:

> "You find that before you go to a certain clinical site, you find that it's, like, the campus did not communicate well with the health institution whether to accept them to bring those students to that clinical site. By the time when you reach there, they look at you as if they were not prepared of you, and like if they don't care much about you. It could be better if the university has a great collaboration with that health institution, so that any assistant with us clinical students we can acquire from the health institution we can be provided to it." (5:7)

> "There should be a meeting of nurses and our supervisors before our orientation day: 'Tell them please these are students.'" (5:2)

3.5 SUMMARY

This chapter discussed the core findings of the study, which were derived from the analysis of data collected through five focus group discussions. The findings discussed centre around two major themes that emerged from the data: nursing students' support

needs during clinical placement, and suggestions to enhance clinical placement at a selected university in Rwanda. The discussion of the findings was supported with direct quotations from the focus group interviews. Chapter 3 paved the way for interpretation and evaluation of the findings in the following chapter (Chapter 4). Chapter 4 discusses the findings of the study and integrates them with relevant recent literature.

CHAPTER 4

INTEGRATED DISCUSSION OF THE FINDINGS AND THE LITERATURE

4.1 INTRODUCTION

Chapter 4 discusses the findings of this study and integrates relevant literature on nursing students' experiences regarding the support they need during clinical placement at a selected university in Rwanda. The purpose of the literature review is to contextualise the study findings within the existing body of knowledge. The process of integrating the study findings into the existing body of knowledge helped the researcher to gain insights into the existing evidence regarding clinical nursing education, and to identify gaps in her study, as well as gaps in the existing body of knowledge. The search was not exhaustive, but it nevertheless yielded a considerable amount of recent literature addressing this research problem. Integration of the research findings with the existing body of knowledge helped the researcher to determine where future studies in clinical nursing education on the research phenomenon investigated might be needed.

A literature search was conducted by accessing a variety of databases, including ProQuest, EBSCOhost, and SAGE Journals online, and by using the search engine Google Scholar. The topic, the study objectives, the conceptual framework that guided the study, and the themes that emerged from the study were broken down into keywords, which were used to guide the literature search. The keywords used were "clinical learning", "nursing students", "clinical facilitation", "student support", "clinical placement needs", "clinical experience", "clinical practice", "clinical supervision", and "Tait's student support framework". The researcher also employed citation tracking to find the recent most influential articles through the reference list of the study and were cited by the articles in her search results.

The discussion applies Tait's framework of student support, which guided the study. Although Tait's (2000:3) student support framework focuses on students in an open distance learning environment, the primary functions of student support, namely cognitive support, affective support, and systemic support, were applied in the clinical setting in this study. Application of the primary functions of student support yielded logical discussions

on the topic of interest and facilitated drawing up of a student support plan for clinical placement, to address the third objective of the study. Girija (2012:26) asserts that nurse educators have a unique ability to assess the cognitive, emotional, and learning strengths and weaknesses of students. Cognitive support relates to educational resources, learning materials, and academic support. The affective dimension of student support relates to students' psychological, social, and physical well-being in the clinical learning environment. The systemic dimension relates to administrative/institutional support, which pertains to the organisational aspect of clinical placement. Effective student support is vital for ensuring a better student experience during clinical placement. This study uncovered various clinical placement needs from participants' clinical learning experiences that need to be taken into consideration when planning student support for clinical placement at a selected university in Rwanda. The student support needs uncovered in this study have not been given any order of priority. They stand in tension with each other, such that while none can be ignored, no need can be given more importance than any other need.

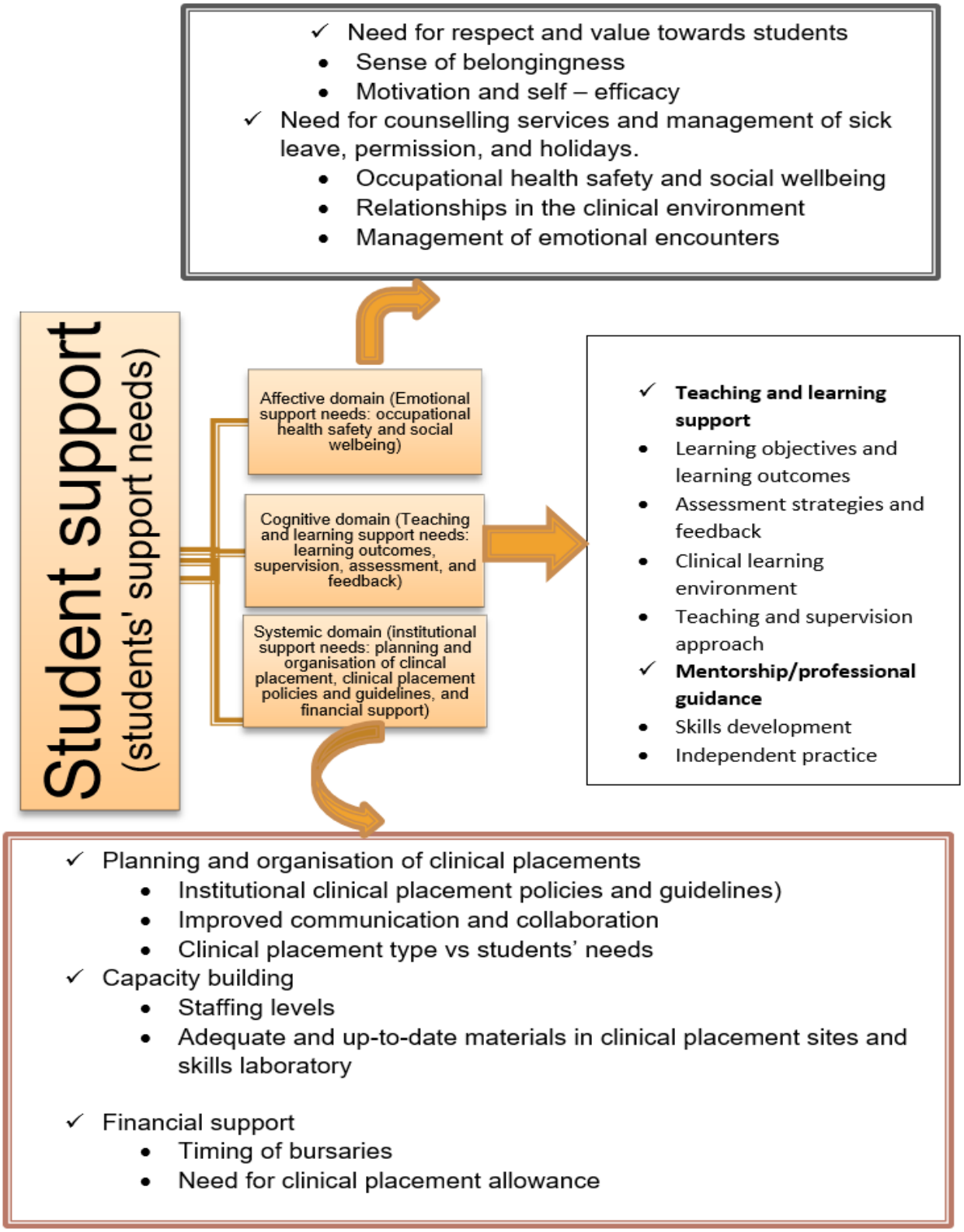

Figure 4.1 Structural application of Tait's framework of student support

(Developed from data obtained in this study and integrated with Tait's (2000) framework of student support)

4.2 AFFECTIVE SUPPORT (EMOTIONAL SUPPORT)

The findings of this study reveal that participants needed emotional support regarding their occupational health and safety and social well-being. The findings suggest that negative behaviours, or reactions, that are acted out, and events or situations during caregiving that emphasise participants' feelings of emotional vulnerability and pessimism, impacted students' clinical learning experiences. Participants shared that the negative and unsupportive work environment led to them questioning their personal self-worth and experiencing a lack of sense of belongingness. They expressed emotions of shame, anxiety, and sadness.

4.2.1 Respect towards students (a sense of belongingness)

Belongingness is an intrinsic feeling of the need to belong to and be accepted by a social group (Gilbert & Brown 2015:24). The clinical learning environment is a social context that requires social interaction between the students, the education providers, and the patients. In the past decade, the inherent need to belong during clinical placement has been a subject of debate in the literature (Van der Riet et al 2018:45; Thomson et al 2017:514; Borrott, Day, Sedgwick & Levett-Jones 2016:29; Gilbert & Brown 2015:24). This suggests that a sense of belongingness is imperative for learning and personal and professional development in the clinical learning environment. Grobecker (2016:178) holds that a sense of belonging is a fundamental need of clinical placement, as it has a significant positive influence on students' learning, motivation, and confidence, although the primary focus of clinical placement is the advancement of students' nursing skills (Borrott et al 2016:31).

Various factors in the literature were identified that play a role in nursing students' perceived sense of belongingness during clinical placement. Being part of the nursing team (Thomson et al 2017:518), developing relationships with staff, feeling a sense of social connection, feeling welcome and receiving support from everyone (Van der Riet et al 2018:45), having someone to turn to when needed (Borrott et al 2016:31), and the length of clinical placement (Gilbert & Brown 2015:27) are factors that were identified as impacting nursing students' sense of belonging during clinical placement.

The findings of the current study reveal that feeling accepted by everyone, feeling welcome, having someone to turn to, receiving support from everyone, and a long placement time contributed to students' perception of a sense of belongingness. They reported that they experienced feelings of stress and depression when they found no one to turn to. Bodys-Cupak, Majda, Kurowska, Ziarko and Zalewska-Puchała (2021:11) explain that a high level of self-worth is required for nursing students to independently utilise active strategies of coping with clinical placement stress.

Participants felt unwelcome and rejected, through the harsh manner in which they were corrected by the nurses, and through the lack of compliance by patients. This finding is in line with Grobecker (2016:178), as the researcher reported that a lack of feeling needed and accepted, and not fitting in, made students feel lonely and rejected. Van der Riet et al (2018:45) confirm this, as in their study they found that the development of good relationships with students during clinical placement made students feel at home and led to a sense of belongingness. Participants reported that they felt neglected when they found no one to support them in the clinical learning environment.

The findings reveal that a lack of sense of belonging contributed to participants' stress and anxiety, which negatively affected their level of confidence. Grobecker (2016:178) conducted a descriptive correlational study to examine the relationship between a sense of belonging and perceived stress among baccalaureate nursing students in clinical placement, using the Perceived Stress Scale for data collection. The results revealed a statistically significant low inverse relationship between sense of belonging and perceived stress, which suggests that there is a small decrease in stress with perceived belonging.

Findings from the current study suggest that the length of clinical placement played a role in nursing students' sense of belongingness. Participants reported that having a short placement time spread across several departments decreased their feeling of belonging, as well as their ability to achieve their clinical learning objectives, since time was spent on orientation and settling in. This finding is in line with Gilbert and Brown (2015:27), who found that short placements resulted in a decreased sense of belonging and limited learning opportunities for students, because time was used for settling in.

4.2.2 Value towards students (motivation and a sense of self-efficacy)

Motivation is a feeling of empowerment, and it is greatly influenced by self-confidence and knowledge (Kennedy, Hardiker & Staniland 2015:490). Self-efficacy has been described as having a great influence on clinical competence among nursing students (Ahn & Choi 2015:1304; Yu, Tong, Li, Wu, Hong & Wang 2021:5). This suggests that motivation and self-efficacy can greatly impact nursing students' competence during clinical placement. Factors that enhance feelings of motivation among nursing students during clinical placement have been identified in studies conducted in diverse settings (Panda, Dash, John, Rath, Debata, Swain, Mohanty & Eustace-Cook 2021:11-14; Ahn & Choi 2015:1305).

Participants in this study identified respect and value, being acknowledged, and a supportive clinical environment as factors that influenced their feeling of motivation and self-efficacy. The findings of this study suggest a strong link between motivation and self-confidence. Participants felt demotivated and questioned their self-efficacy when they were disrespected, not supported, and talked down to in front of patients. Consistent with the findings of this study, Kennedy et al (2015:490) found that lack of support and lack of recognition were factors that impeded nursing students' feeling of empowerment during clinical placement. Supporting this finding, Panda et al (2021:11) found that being actively involved in clinical placement activities gave students the feeling of being part of the team, and it significantly contributed to their enthusiasm to learn.

Yildirim and Dalcali (2020:2054) investigated the effects of clinical learning challenges on students' anxiety levels and motivation, and they recommended collaboration between students, education providers, health institutions, and academic institutions, to minimise clinical placement challenges and thus improve students' motivation. Bodys-Cupak et al (2021:1) found that nursing students' ability to cope with the clinical placement challenge of stress depended on their sense of self-efficacy.

4.2.3 Relationships and safety in the clinical environment

The complex and dynamic nature of the clinical learning environment and relationships between key stakeholders involved in clinical education influence clinical learning experiences (Van der Riet et al 2018:45). Sound interpersonal skills have been identified

by nursing students as one of the qualities of the best clinical facilitators (Girija 2012:26). Sundler, Blomberg, Bisholt, Eklund, Windahl and Larsson (2019:23) found that preceptors' attitudes were important aspects that impacted students' learning during clinical placement. Gilbert and Brown (2015:24) hold that the challenges of the clinical learning environment are directly linked to the lack of students' social connection to the clinical environment and facilitators of their clinical learning. They argue that a long placement time facilitates the development of trust and leads to optimum clinical learning experiences (Gilbert & Brown 2015:25).

The findings from this study suggest that the atmosphere of the clinical learning environment, the category of nurses and nursing students, the attitudes of the supervisor/peers, and nurses' number of years of experience played a role in relationship building in the clinical learning environment. According to Girija (2012:26), to create a safe and nurturing clinical environment requires that healthcare education providers apply ethical behaviours that encourage a good student-healthcare education provider relationship.

Teamwork and peer support were important aspects mentioned by the participants, as they were feasible with students studying for the same qualification, or with nurses with the same or a higher qualification. Development of a negative attitude and scrutiny was common with nurses with a lower qualification. This suggests a tense clinical environment. Panda et al (2021:11) highlighted that a lack of positive communication leads to a decrease in social connection and demotivation in the clinical environment.

Participants' physical safety and social well-being were determined by the availability of personal protective equipment, management of work accidents, sick leave, holidays, permission, and emotional experiences. Participants felt that their physical health and safety was threatened by the short supply of personal protective equipment.

4.3 COGNITIVE SUPPORT (TEACHING AND LEARNING SUPPORT)

Cognitive support relates to assistance regarding clinical teaching and learning in the clinical learning environment.

4.3.1 Clinical learning environment

Student perceptions of satisfaction with the clinical learning environment have been a subject of debate in the literature. Rodríguez-García, Gutiérrez-Puertas, Granados-Gámez, Aguilera-Manrique and Márquez-Hernández (2020:992) found that satisfaction with the learning environment was higher in learning environments that were perceived as favourable for learning and had adequate supervision. Relationships and willingness to support students were mentioned as favourable factors for a good clinical learning environment. Similarly, Donley and Norman (2018:42) found that enabling students to engage in deeper learning through analysis, evaluation, and demonstration of synthesis of learning through managed autonomy in practice is a characteristic of a high-quality learning environment.

A supportive clinical environment is one that allows time for reflection and discussion (Sundler et al 2019:24). Participants viewed allocation of time for discussion as important for them to reflect on their experiences and share their learning experiences with peers and supervisors to build on future experiences. Morley (2014:69) emphasises the need for universities to use online communication tools that students are familiar with to complement support mechanisms available for practice learning. Rodríguez-García et al (2020:991) found that students placed value on the need to easily interact with staff in the clinical placement environment, and that this was important for positive attitudes, respect, and approval.

Kim and Yang (2015:417) studied the effects of the clinical learning environment on clinical practice stress and anxiety in nursing, and they found that the factors that contributed to stress were the atmosphere of the clinical learning environment, satisfaction with the department, and social support. Students' relationships with staff contributed to the climate in the clinical placement environment, as well as students' motivation to learn and to continue in the nursing profession.

4.3.2 Theory-practice integration and the achievement of learning outcomes

Theory-practice integration is achieved when what is observed during clinical practice placement is consistent with what was learnt in theory, and when learning objectives are achieved at the end of clinical placement. Sundler et al (2019:23) emphasised the need

to align students' clinical learning needs with their educational background. Clinical practice is an imperative in nursing education; however, it is flawed by a discrepancy between knowledge gained in the classroom and what is observed in clinical placement (Panda et al 2021:12). Nursing students improve their knowledge and skills during clinical placement through repeated practice of procedures to increase their cognition and their capability to provide unsupervised care to real patients (Arpanantikul & Pratoomwan 2017:125). So, clinical supervisors need to be able to motivate students to utilise available clinical learning resources to achieve effective clinical learning (Girija 2012:25).

One of the findings of this study was that what was learnt in theory was often different from what was observed in practice. The study findings identified some inadequacies in the clinical environment and in the professional skills and knowledge of some nurses and supervisors that were assigned to students as facilitators of their learning, which limited students' ability to achieve their learning objectives and properly integrate theory and practice. Lack of materials, poorly accessible placement sites, inadequate knowledge, work overload, poor alignment of learning objectives and clinical placement sites, and lack of support were cited as the major reasons for the theory-practice gap. This finding is supported by Alharbi and Alhosis (2019:10), who reported that lack of knowledge among staff, lack of willingness to teach among some preceptors, infrequent supervision and follow-up, and inappropriate treatment by staff contributed to the theory-practice gap. Arpanantikul and Pratoomwan (2017:128) reported that students preferred supervisors to supervise all procedures, to increase their level of confidence and facilitate faster transfer of knowledge and skills. This suggests that close supervision is an important aspect of theory-practice integration. Salamonson, Everett, Halcomb, Hutchinson, Jackson, Mannix, Peters and Weaver (2015:209) cited lack of interest in teaching students among facilitators as one of the reasons for students' dissatisfaction with their clinical learning experiences.

4.3.3 Assessment strategy and feedback

Performance assessment, reflection, and feedback are described as valuable for students' learning during clinical placement (Sundler et al 2019:21). Calleja, Harvey, Fox and Carmichael (2016:167-170) developed a tool that could help students engage with their feedback. This tool assisted students to develop self-assessment skills, by reflecting on and engaging with feedback from previous workplace experience, to develop goals,

learning outcomes, and strategies to improve performance. Both students and supervisors reported that the tool was helpful, although barriers to performance improvement were identified. It was reported by students that the tool helped them to focus their attention on what needed to be improved, while supervisors felt the tool helped them to focus on the specific needs of each student. This finding emphasises the role of feedback on performance as a strategy for effective learning during clinical placement. Students described preceptors that were supportive and helpful as ones that followed up on their learning and delivered constructive feedback (Williams, Al Hmaimat, AlMekkawi, Melhem & Mohamed 2021:679).

A concern raised by the participants was that timely feedback after assessment was seldom received, or feedback received was negative and unconstructive. This finding is supported by Girija (2012:26), who reported that supervisors who were competent, who knew how to teach, and who were able to provide individualised, timely, constructive, and specific feedback were viewed by students as supervisors with the best qualities. Sundler et al (2019:23) emphasise the need for feedback that is not too negative or critical.

Concerns were raised regarding the assessment strategies. The participants were dissatisfied with the assessment strategies. Participants reported that evaluations were not strict, that they were sometimes not aligned with the learning objectives, and that students did not get evaluated in all departments. This is consistent with a study by Girija (2012:26), who reported that students preferred evaluations that reflected the learning objectives and were fair and objective.

4.3.4 Teaching and supervision approach

It is the responsibility of clinical facilitators to identify effective learning strategies that can help improve students' performance during clinical placement (Arpanantikul & Pratoomwan 2017:128). Clinical supervision is important to ensure that students practise safely in the clinical environment what they have learnt in theory, while gaining practical skills (Girija 2012:25). The core skills of clinical supervisors are their ability to structure learning activities and the learning environment (Girija 2012:25). The findings of this study reveal that the student-supervisor ratio, professional competence, accessibility, and interpersonal skills were factors that played an important role in clinical teaching and supervision. Participants felt supported when supervisors were available to them in the

clinical setting and had sufficient knowledge and skills to provide guidance and support. Participants felt that they were not supported, due to the high student-supervisor ratio, of about 20:1, which resulted in supervision that was lacking in frequency and quality. Supervisors have the responsibility to set aside time for reflection and discussion on intended learning outcomes (Sundler et al 2019:21) and to facilitate critical thinking (Girija 2012:26).

4.4 SYSTEMIC SUPPORT (INSTITUTIONAL SUPPORT)

Systemic support relates to administrative assistance provided to students during clinical placement that meets their needs and interests.

4.4.1 Planning and organisation of clinical placement

The quality of support that students receive during clinical placement depends on its planning at the institutional level. Successful planning and organisation of student support were important to the participants, as they felt that it requires a holistic approach that includes students' needs and financial ability, as well as collaboration and effective communication between the university and the clinical placement site personnel. In their study, Salamonson et al (2015:209) reported that students found clinical facilitators' support negative and challenging, because the student support was teacher-centred and did not take into consideration students' learning needs. Kim and Yang (2015:417) recommend more collaboration between nursing universities and teaching hospitals, to optimise clinical learning. Similarly, Williams et al (2021:681) assert that constant collaboration between the healthcare facility and the nursing education programme and faculty is imperative in addressing the factors that affect students' learning during clinical placement.

4.4.2 Capacity constraints

Capacity constraints in terms of learning materials at clinical placement sites, a skills laboratory, and low staffing levels at clinical placement sites and the university institution were identified. Participants felt that their learning outcomes and overall competence were greatly affected by these capacity constraints. Gilbert and Brown (2015:25) reported

that low staffing levels left nursing students feeling not supported, which could lead to superficial learning and attrition.

4.4.3 Financial support

Financial support emerged as impacting students' learning during clinical placement. Participants felt that financial support placed a strain on students who were government-sponsored. They said that the same bursary amount was given to students in all programmes, without consideration of the additional financial needs of clinical placement, including accommodation, transportation, and food. Participants reported that financial inability resulted in students being evicted from their accommodation, missing days at placement sites due to hunger, or selling their valuables to survive.

4.4.4 The need to improve communication

The findings of this study reveal that communication was hindered by a language barrier between students and patients, and between nurses and students. Time was spent in translation, and information was lost during translation. Williams et al (2021:679) reported that students missed valuable information when nurses used their native language during clinical placement, while the students had studied in English. Salamonson et al (2015:210) reported that students who were native English speakers were dissatisfied with their clinical placement, and facilitators' lack of engagement in teaching was cited as the reason for their dissatisfaction. The same authors conducted a mixed methods study with nursing students with varied backgrounds from four universities in Australia. The study was designed in English, and English was not the first language of all participants. The qualitative part of the study allowed for two comments regarding satisfaction with clinical learning experiences. The native English speakers may have been more confident in their command of written English, and students for whom English was not their first language may have been dissatisfied with their clinical learning experiences but lacked confidence in their command of written English. The above two studies suggest that students' first language may not have been linked to their dissatisfaction with clinical learning experiences.

4.5 SUMMARY

Chapter 4 discussed nursing students' views and perceptions regarding the support they need during clinical placement, as articulated during focus group interviews on the topic "A student support plan for clinical placement of nursing students in Rwanda". Themes, categories, and subcategories that emerged from the data was grouped under the three dimensions of student support discussed, and they were supported by relevant recent literature. The discussed themes as applied to Tait's framework of student support, which guided the study, were emotional support, educational support, and institutional support. Chapter 5 presents the conclusions, limitations, and recommendations of the study.

CHAPTER 5

CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

5.1 INTRODUCTION

In Chapter 4, the researcher integrated the literature with the data that was gathered during the focus group interviews. Chapter 5 presents the conclusions, limitations, and recommendations of the study. The purpose of the study was to propose a student support plan for clinical facilitation, to enhance the clinical learning of nursing students registered for an undergraduate nursing programme at a selected university in the Republic of Rwanda. The objectives were to explore and describe the clinical learning experiences of nursing students during clinical placement, to describe the support needs for clinical learning according to the cognitive, affective, and systemic dimensions of student support, and to draw up a student support plan for clinical placement. Objective 3 is addressed in this chapter, by providing a student support plan for clinical placement, which thereby also achieves the purpose of the study.

5.2 SUMMARY OF THE METHODOLOGY

A qualitative, exploratory, descriptive, and contextual design was employed to reach the objectives of the study. The researcher adopted the philosophical ideas of a constructivist, while approaching the data through an inductive lens. The population for this study was second-year to fourth-year undergraduate nursing students at a selected university in Rwanda. The initial plan was to include all first-year to fourth-year students, but the first-year students had not attended at least eight weeks of clinical placement, due to Covid-19 restrictions, so they had no clinical learning experience to share.

Data was collected through five focus group interviews. To reach the study objectives, an interview guide was used with open-ended questions. Data was analysed in accordance with Creswell and Creswell's (2018:268-270) data analysis cycle, which consists of the following five steps: step 1: organise and prepare the data for analysis; step 2: read or look at all the data; step 3: start coding all the data; step 4: generate a description and themes; and step 5: represent the description and themes. The data analysis process is

summarised here. First the researcher familiarised herself with the data, by reading and rereading the transcripts and listening to the audio recordings. She then read through the transcripts several times while taking notes. Sections of the text with similar words and sentences were highlighted, and labels were formulated (coding). The researcher then identified patterns in the codes that formed concepts (subcategories). She then combined and named the patterns (categories). Patterns that appeared often in the data was kept, and those that did not appear often and did not make sense were discarded. Categories that resonated with a broader meaning of the data was grouped together and given a collective name (themes). The researcher then defined and explained the named patterns according to the context of the data. The data was then interpreted and checked for contradictions. Trustworthiness and ethical principles were adhered to.

5.3 CONCLUSIONS DRAWN FROM THE STUDY

Based on the findings presented in Chapter 3, and the discussion of the literature in Chapter 4, the researcher formulated the following conclusions. The conclusions are first presented in terms of the demographic data, and then in terms of the proposed student support plan for clinical placement which includes the three dimensions of student support.

5.3.1 Demographic data

The age range of the participants was 20 to 25 years, which shows that they were still young. The participants' age range suggests that they were new to the nursing profession, with no prior professional experience in nursing, and therefore needed support during clinical placement to develop their professional skills and competencies.

5.3.2 Conclusions related to emotional support

The findings suggest that good relationships are a prerequisite for building trust and respect in the clinical environment. When the students were acknowledged as being part of the team, it gave them a feeling of belongingness, acceptance, and support, and it thus positively influenced their learning. In their study, Webster, Bowron, Matthew-Maich and Patterson (2015:40) found that the actions and attitude of nursing staff, and their willingness to teach, are influential factors in student learning during clinical placement.

The authors explain that negative behaviours of nursing staff can decrease students' confidence, learning, and desire to continue in the nursing profession. The findings of the current study suggest that professional socialisation and team building in clinical learning environments are important aspects of emotional support. It is therefore important to treat students with empathy and respect, to ensure the building of trusting relationships in the clinical environment.

The need for physical health and safety in the clinical environment emerged as impacting on students' learning and psychological well-being. Injuries and exposure to depressing experiences, and infections due to students' having insufficient personal protective equipment (PPE), negatively affected their learning. Participants reported that they felt stressed when they experienced such circumstances, with no one to provide care or counselling to them. It is therefore important to consider occupational health and safety when planning for student placement support.

Financial constraints impacted students' learning during clinical placement. Participants felt that clinical placement put a strain on their financial ability. Distant clinical placement sites that were inaccessible in terms of transportation and accommodation were viewed as causing participants stress. Participants preferred clinical placement sites that were close to the campus. Distant clinical placement sites required that students transport household items and find new accommodation. This was viewed by students as double expenditure, because they found themselves renting two accommodations at the same time, namely one at the clinical placement site and another at the campus. Distant placement sites had implications for students' safety and security. It is therefore important to consider individual students' financial ability when planning for students' placement support. In their study, Van der Riet et al (2018:45) reported that clinical placement sites that were located close to the university were advantageous to students, and that travelling to distant sites placed a considerable burden on students. Government benefits, such as student bursaries and a clinical placement allowance, are an important factor to provide students with financial security.

5.3.3 Conclusions related to teaching/learning support

Teaching and learning support in clinical placement requires that the knowledge learnt during theoretical learning be applied practically, by implementing it in real patient care.

Salamonson et al (2015:206) assert that students' placement experiences can affect the quality of their learning. Participants viewed supervisors as being primarily responsible for creating learning opportunities that can help them become competent nurses. They felt that supervision was lacking in quality and quantity, and they questioned whether learning outcomes were achieved, as well as the safety of their practice. Participants felt that they were working as if they were nurses when they carried out unsupervised procedures or were asked to perform procedures above their level of competence. Webster et al (2015:47) state that clinical teaching and effective supervision are important for quality of care, patient safety, and patient satisfaction. McPherson and Wendler (2020:522) define safe clinical practice as a patient-student situation within a live clinical environment which occurs when pre-licensure nursing students who have been adequately prepared demonstrate knowledge of the clinical situation and its risks, communicate with faculty and staff members professionally, and develop appropriate relationships with faculty and staff. As such, effective supervision is important to enable students to safely apply theoretical knowledge to practice, while gaining experience to become competent autonomous nurses.

Frequent strict assessment and feedback on performance were viewed by participants as important for clinical learning. Calleja et al (2016:168) state that both oral and written feedback on performance are essential to help students to learn effectively, because the formative and the summative assessment components of clinical placement both contribute to the final grade in practical nursing education. Participants in the current study felt that frequent structured assessment in all departments was necessary to prepare them for the licensure examination. They said that feedback was essential for them to reflect on their experiences and build new knowledge and skills. Therefore, assessment and feedback on performance are a prerequisite for nursing students to achieve professional standards during clinical placement.

The need to align clinical learning objectives with the capacity of the clinical placement sites in terms of quality of materials and number of staff emerged as important to ensure the achievement of clinical learning outcomes.

5.3.4 Conclusions related to institutional support

Participants viewed effective planning and organisation of student support at the institutional level as imperative for the quality of support that students receive during clinical placement. The need for assessment of clinical placement sites, prior to placement, in terms of their suitability for students' learning needs and expected outcomes was highlighted.

Effective communication and collaboration between the university and the health institution emerged as important to ensure that students are accepted as team members and are sufficiently supported in the clinical environment. Parchebafieh, Memarian and Vanaki (2020:1) reported that acceptance of the student in the ward as a member of the care team was important for improving the psychological atmosphere of the ward, and that it contributed to students' motivation and spontaneous learning. Donley and Norman (2018:39) found that a tripartite meeting between students, their mentors, and zoned academics supported students' learning, as they benefited from increased diversity in learning opportunities and clarification of the alignment of practice with learning outcomes and the scope of practice.

Lack of effective feedback channels and lack of follow-up on implementation of university clinical placement policies and achievement of clinical learning outcomes had implications for adequate preparation of students to become competent healthcare providers.

Effective planning and organisation of student support, effective communication, and collaboration are important to ensure quality institutional support to students during clinical placement.

5.4 LIMITATIONS OF THE STUDY

The first-year students in the bachelor's degree nursing programme of the selected institution did not participate in this study, due to Covid-19 restrictions, which prevented them from gaining clinical experience as initially planned. Therefore, the population of this study was second-year to fourth-year nursing students registered for the bachelor's (undergraduate) degree programme leading to registration as a nurse, and the results of

the study are therefore only representative of second-year, third-year, and fourth-year students.

The study was carried out at only one nursing institution.

The assistant focus group moderator was a staff member at the selected university institution, but he was not an instructor in the bachelor's degree nursing programme. This may have caused participants to withhold some information. Nevertheless, confidentiality was ensured, and the assistant focus group moderator signed a confidentiality binding agreement (see Annexure 8).

The perspectives of the clinical supervisors, the clinical site nurses, the health institution managers, and the nursing education institution managers were not considered. It was not within the scope of this study to include these stakeholders, but inclusion of their experiences could have added value to the student support plan for clinical placement which emanated from the study. Therefore, it is recommended that similar studies be carried out with clinical supervisors, clinical site nurses, health institution managers, and nursing education institution managers, to obtain insight into their perspectives.

5.5 A STUDENT SUPPORT PLAN FOR CLINICAL PLACEMENT OF STUDENTS

To address the purpose of the study, a student support plan for clinical placement of students was developed according to the affective, cognitive, and systemic dimensions of clinical facilitation, to enhance clinical learning at a selected university in Rwanda. The student support plan reflects students' clinical placement needs that emerged from the data.

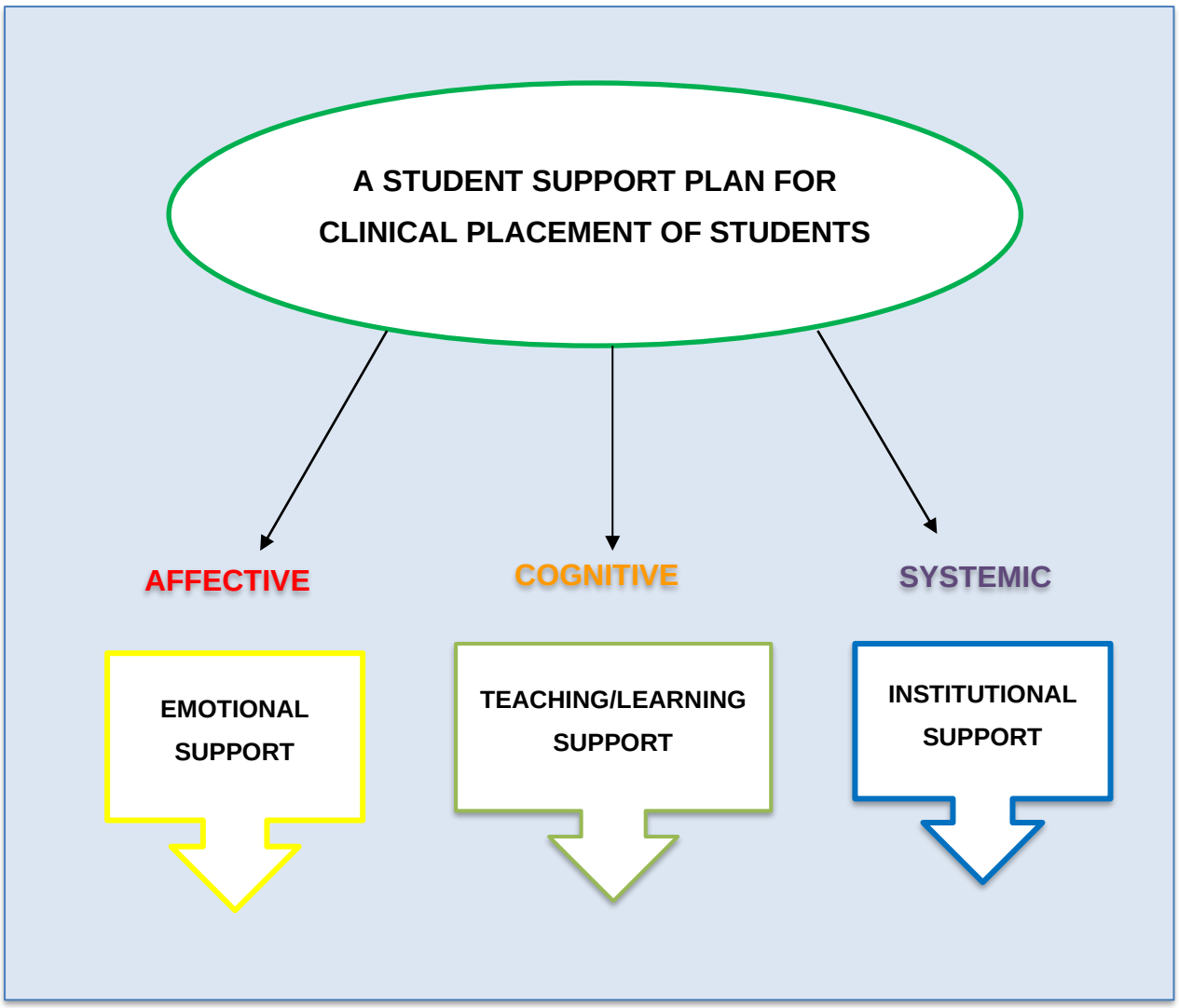

Figure 5.1 A student support plan for clinical placement of students (Objective 3)

The following tables elaborate on Figure 5.1 above.

A student support plan for clinical placement of students is important because it can be useful in clinical nursing education as follows.

To begin with, it can be used as a guide when planning for students' clinical placement and could support students in practice through contribution to the improvement of the quality of students' learning experience and academic success in clinical nursing education. It could inform curriculum development for clinical nursing education that focuses on students and hence increase the diversity of students' learning experience. It can lead to the strengthening of relationships between stakeholders involved in clinical nursing education and ease accessibility of information regarding systemic issues and processes in clinical nursing education. It can stimulate the development of

policies/strategies that could help manage physical/mental health issues, shape moral values/professional conduct, and ensure teaching/learning quality assurance in the clinical learning environments. Finally, a student support plan for clinical placement of students could be used with further research to devise a framework for a student support plan for clinical placement of students.

Table 5.1 A student support plan for clinical placement of students regarding emotional support

EMOTIONAL SUPPORT
✓ Value and respect/relationship building • Foster soft skills development • Foster the building of inclusive cultures in the clinical environment • Foster oral and written communication skills ✓ Motivation and self-efficacy • Encourage teamwork/peer support • Promote positive self-esteem/self-efficacy • Foster mentorship • Encourage professional development and autonomy ✓ Sense of belonging • Create a welcoming clinical environment ✓ Physical health and psychological well-being • Ensure a continuous supply of PPE • Manage work-related accidents • Provide access to counselling services, to reach out to students in times of distress • Regularly survey students about mental health in the clinical environment • Watch out students' working hours • Make time for socialisation, fun, and humour in the clinical environment • Watch out for signs of depression in students • Ensure that public holidays are respected

Table 5.2 A student support for clinical placement of students regarding teaching/learning support

TEACHING/LEARNING SUPPORT
✓ Learning objectives and learning outcomes • Align learning objectives with students' level of knowledge and skills needed to achieve the learning outcomes • Align learning objectives with students' needs • Set measurable learning objectives • Follow up on the achievement of learning outcomes ✓ Teaching and supervision approach • Frequent supervision • Collaborative approach to supervision • Creation of learning opportunities • Recognition of students' abilities • Create time for discussion ✓ Assessment/evaluation and feedback • Alignment of evaluation with learning objectives • Formative and summative assessments in all departments • Effective feedback channels • Reflection on feedback ✓ Clinical learning environment • Supportive clinical environment • Constant assessment of students' perceptions of the clinical environment

Table 5.3 A student support plan for clinical placement of students regarding institutional support

INSTITUTIONAL SUPPORT
✓ Pre-placement planning • Assessment of clinical placement sites for availability of materials, accessibility, availability of learning opportunities, and staffing levels • Communication with clinical placement sites regarding readiness to accept students at clinical placement sites • Organisation of student accommodation at clinical placement sites • Communication with students, integrating students' financial ability and individualised needs, while allowing flexibility regarding choice of placement site • Pre-placement orientation of students regarding students' expectations from clinical site nurses, and expectations from supervisors ✓ Planning at placement site • Orientation on the first day of placement • Meeting and discussion with health institution representative, clinical site nurses, and students regarding students' expectations, expected learning outcomes, permission, working hours, and sick leave ✓ University policies • Clinical supervision guidelines • Student core competencies • Student core values • Assessment/evaluation guidelines • Guidelines on management of workplace accidents • Feedback framework ✓ Health institution policies • Awareness of the scope of nursing practice • Awareness of the code of conduct ✓ Support for students • Supply of adequate PPE • A placement accident support plan • Follow up on reinstitution of a clinical placement allowance • Increase the number of supervisors • Follow up on the implementation of a memorandum of understanding between the university institution and health institutions • Accessibility of counselling services

- Allocation of one hour every day and a specific room at the placement site for group discussions, a review of theory, and reflection on clinical learning experiences
- Orientation and training of clinical site nurses
- Availability of clinical placement facilitators at placement sites
- Availability of specialist supervisors
- A Kinyarwanda medical dictionary

✓ Organisation of placement

- Alignment of the clinical placement model with students' needs
- Alignment of clinical placement sites with students' theoretical knowledge and skills
- Alignment of supervisors' tasks with their knowledge and skills
- Evaluation of students in all departments
- Frequent performance assessments
- Planning of student support
- Frequent assessment of students' needs
- Follow up on implementation of clinical placement guidelines, evaluation guidelines, and students' achievement of the clinical learning objectives

5.6 RECOMMENDATIONS

For the purposes of this study, recommendations are offered here for student support in clinical nursing education and for further research. These recommendations are based on the findings of the study and the gaps identified in the literature.

5.6.1 Recommendations for student support in clinical nursing education

The recommendations for student support in clinical nursing education are based on the findings regarding the support needs of nursing students during clinical placement. The following recommendations for student support in clinical nursing education are offered:

- Specific policies that integrate student placement support needs should be developed. Student input can be ensured through ongoing and post-placement reviews and three-way conferencing between students, clinical site nurses, and nursing institution clinical placement coordinators.
- Nursing institution clinical placement coordinating staff should use a holistic approach when organising student placement support planning.

- Nursing education institutions should constantly monitor the clinical placement needs of students, to inform student support planning.
- Nursing education institutions should provide clear student feedback channels that will respond to student concerns, as well as feedback on performance within a specified period, during clinical placement. This can be ensured by including clinical site nurses and students in the feedback process, to reduce congestion in communication and hence improve the turnaround time for delivering information and services, to ensure more support to students during clinical placement.
- Nursing education institutions and healthcare institutions should work together to ensure acceptable staffing levels and an acceptable student-supervisor ratio at clinical placement sites. This can be achieved through the planning and implementation of clinical placement quality assurance/quality control policies.
- Guidelines should be provided stating students' rights and responsibilities, as well as those of their supervisors and clinical site nurses, which can be implemented through effective oversight by clinical placement coordinators and nurse managers, as well as through incentive in-service training programmes for clinical site nurses, which could boost their morale.
- Clear learning and assessment methods for clinical facilitation should be provided, which can be ensured through close alignment of learning objectives with assessment and instructional strategies.
- The design and development of clinical placement policies should cover the teaching/learning, emotional, and institutional dimensions of clinical placement.
- Adequate and up-to-date materials, such as gloves, medical instruments, clinical portfolios, and logbooks, should be provided to students at clinical placement, and skills laboratory.
- Nursing education institutions should make use of online community spaces, such as institutional virtual learning environments, and they should use mobile technologies, such as WhatsApp instant messaging, and discussion forums, such as digital web conferencing tools, to allow supervisors to interact with students, and students to interact with their peers, during clinical placement.
- Nursing education institutions should consider the use of incentives, or professional development opportunities, that help prepare nursing staff for their role as facilitators of students' learning in the clinical environment, so that they can feel more motivated to provide support to students.

- Nursing education institution managers should ensure support to nurse educators, by fostering good characteristics of relationship building, such as approachability, role modelling, and effective communication skills, through periodic orientation programmes.

5.6.2 Recommendations for further research

The recommendations for further studies are based on the gaps identified in the literature and the insights gained from the findings regarding student support needs during clinical placement.

This study focused on the perspectives of students, and thus no insight was gained into the perspectives of nursing staff and supervisors. Further studies are therefore needed to determine the perspectives of clinical site nurses, health institution managers, clinical supervisors, and nursing education institution managers.

The findings suggest that student support needs may differ according to year of study. Further research is thus required to provide insights into student support needs according to year of study.

A gap in the literature was identified in terms of studies addressing the management and support of nursing students' physical health and psychological safety during clinical placement. It will be beneficial for such studies to be carried out.

5.7 CONCLUSION

Provision of excellent clinical nursing education depends on the quality of support that students receive during the integration of theory and practice in the clinical environment. Collaboration, effective communication, and a holistic approach to the organisation of student support that effectively aligns students' emotional, educational, and institutional support needs with available support services, materials, and resources are beneficial to ensure that students are supported, and therefore that clinical learning is enhanced. This research provides insights into students' support needs during clinical placement, as well as student support dimensions to consider when organising student support. It emphasises inclusion of the perspective of students in the planning of student support.

It is imperative that student support planning for clinical placement of students encourage more student input in educational planning. It is vital to ensure consistency in the assessment of students' learning needs and interests, communication regarding target curricular outcomes, students' achievement of learning outcomes, and periodic review of students' clinical placement progress in terms of the cognitive, the affective, and the systemic dimensions of student support. Useful information regarding curricular development in clinical nursing education, such as identification of students' learning style preferences, best teaching strategies, and students' motivation, could be gathered in the process of student support planning.

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ANNEXURES

Please Note: The title of the study was refined and approved by the College Research Ethics Committee of the College of Human Sciences, Unisa on the 22 November 2021. Some of the original documents may still display the initial title as depicted in the original ethics clearance certificate, as it was submitted as such at the time.

Annexure 1(a): Amended ethics clearance certificate from the Unisa College of Human Sciences Research Ethics Review Committee

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

22 November 2021

NHREC Registration # :
Rec-240816-052
CREC Reference # :
63424819_CREC_CHS_2021

Dear Vera Nkfukfu Ndifon

Decision:
Ethics Approval Amendment certificate is valid from 22 November 2021 to 19 February 2023

Researcher(s): Name: Vera Nkfukfu Ndifon
Contact details: 63424819@mylife.unisa.ac.za
Supervisor(s): Name: Prof Gisela H van Rensburg
Contact details: vrensgh@unisa.ac.za

Title: Student support plan for clinical placement of nursing students in Rwanda.

Degree Purpose: MA

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is valid until 19 February 2023.

The ***low risk application*** *was reviewed by* ***Research Ethics Committee: Department of Health studies on the 19/02/2020*** *with reference-* ***HSHDC/951/2020*** *and* ***amended*** *by* College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the

Open Rubric.

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confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.

5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date **(19 February 2023)**. Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

*The reference number **63424819_CREC_CHS_2021** should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature :

Prof. KB Khan
CHS Research Ethics Committee Chairperson
Email: khankb@unisa.ac.za
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Executive Dean : CHS
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Annexure 1(b): Original ethics clearance certificate from the Unisa Department of Health Studies Research Ethics Committee

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 11/02/2020.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee,*

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RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

19 February 2020

Dear Vera NKfukfu Ndifon

Decision: Approval

HSHDC/951/2020

Student: Vera NKfukfu Ndifon

Student No: 63424819

Supervisor: Dr HC de Swardt

Qualification: PhD

Joint Supervisor:

Name: Vera NKfukfu Ndifon

Proposal: Supporting nursing students' clinical learning in Rwanda

Qualification: MA

Risk Level: Low

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 19 February 2020 to 19 February 2023.

Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *You are required to submit an annual report by 30 January of each year that indicates that the study is active. Reports should be submitted to the administrator HSREC@unisa.ac.za. Should the reports not be forthcoming the ethical permission might be revoked until such time as the reports are presented.*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof JM Mathibe-Neke
CHAIRPERSON
mathijm@unisa.ac.za

Prof KM Masemola
DEAN OF COLLEGE OF HUMAN SCIENCES

Annexure 2: Permission letters from the University of Rwanda

The University of Rwanda
June 27 2020

Tel: [redacted]305
vwndifon@gmail.com

Email: 63424819@mylife.unisa.ac.za

Director of Research and Innovations.

RE: AN APPLICATION TO REQUEST FOR RESEARCH AFFILIATION

Dear Sir,

I am writing to request for research affiliation in your institution. I am Mrs Vera Nkfukfu Ndifon a registered student of the University of South Africa studying for the Degree: Master of Arts in Nursing Science. I plan to conduct a research study at the School of Nursing and Midwifery, in your university. The study will require that the researcher gains access to all students enrolled for the A0 general nursing programme who have been purposefully selected as the study population for this Research. For the purpose of this study, data will be collected in conference halls in one of the campuses of the college of medicine and health sciences. The study is entitled: "Supporting nursing students' clinical learning in Rwanda" which has been given ethical clearance from my home university's (UNISA) research ethics committee, under the number.....HSHDC/951/2020.

Thank you for your kind consideration.

Enquires:

Dr. H C De Swardt, Tel: [redacted]06 or email: dswarhc@unisa.ac.za, rina[redacted]wardt@gmail.com: Supervisor.

Prof. [redacted]ritz, Tel: +27-82[redacted]703 or email: maritje@unisa.ac.za, Head of the Department of Health Studies' Ethics Committees.

Yours Sincerely,

[redacted] Ndifon

UNISA

Enquiries: Dr HC De Swardt
Tel: + (27) 12 429 4506
Cell: + 27) 72 518 8003
Email: dswarhc@unisa.ac.za

TvW Building
Room 7-181
Muckleneuk Campus
UNISA
Pretoria
South Africa
26 July 2018

TRUE COPY OF THE ORIGINAL
14 SEPT 2021

RE: BACKGROUND INFORMATION TO RESEARCH STUDY: SCHOOL OF NURSING AND MIDWIFERY, UNIVERSITY OF RWANDA

Head: School of Nursing and Midwifery

Ms Vera Nkfukfu Ndifon, registration number, 63424819 is a student registered for her proposal module of the Master of Arts in Nursing Science degree, at the University of South Africa. In order for her to prepare her proposal, she needs background information of the research setting. She intended to conduct the research within the University of Rwanda, School of Nursing and Midwifery, specifically with undergraduate nursing students who are registered at this university. The research is about student nurses' experiences in the clinical field. We kindly request permission to obtain more information of the nursing programme and students.

PAID ..... 150 ..... RWF
14 SEPT 2021

We appreciate your assistance.

Approved 30/7/2018

Yours sincerely

Dr HC de Swardt and Ms Vera Nkfukfu Ndifon

Notary
MUSHIMIYIMANA Evode

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

Annexure 3: Affiliation letter from the University of Rwanda

UNIVERSITY of RWANDA

DIRECTOR OF RESEARCH AND INNOVATION

TRUE COPY OF THE ORIGINAL

LOCAL SUPERVISION FORM FOR UR AFFILIATES

INTRODUCTION

The University of Rwanda (UR) like other Universities and Research Institutes is delegated by Rwanda Regulations to affiliate the following types of researchers and facilitate Ethics Clearance and Research Clearance:

1. Researchers from outside Rwanda who are not Rwandan Nationals
2. Researchers who are Rwanda Nationals (either from outside or from within Rwanda) who are not employees of Higher Learning or Research Institutions

Local supervision for UR affiliates

One of the requirements to be affiliated to UR for international applications is to get a local supervisor from one of the Colleges of the University of Rwanda. The nomination of the local supervisor of the affiliate is done by direct line manager of the supervisor. Though the applicant may suggest the local supervisor to him/her; the decision to confirm or not the supervisor is done by direct line manager. Therefore, after the supervisor is nominated; he/she commits to supervise the affiliate, sign and the line manager sign.

PAID 1950 14 SEPT 2021

1. Dr. Madeleine Muk[illegible] [illegible] lecturer [illegible] [illegible] +250 [illegible]

.............(Names of Local supervisor, academic rank, work position, email and telephone number)
from University of Rwanda-College of Medicine and Health Science

commit my-self to supervise [illegible] (Names of the affiliate) from University of South Africa (University/Institution of affiliate) who is doing a study entitled: "Supporting Nursing Students' Clinical [illegible] in Rwanda"

.... I will make sure the affiliate, while in Rwanda, gets research space and access to the library. Any cost related to this supervision will be covered by the affiliate.

Names of Local supervisor Dr. Madeleine Muk[illegible]	**Names of Line manager** Assoc. Prof. [illegible]
Signature [signature]	**Signature** [signature]
Date 20/08/2020	**Date** [illegible]

Notary MUSHIMIRE [illegible]

P.O Box 4285 Kigali, Rwanda | info@ur.ac.rw | www.ur.ac.rw

Annexure 4: Local supervisor commitment letter

UNIVERSITY of RWANDA

DIRECTOR OF RESEARCH AND INNOVATION

TRUE COPY OF THE ORIGINAL
On
14 SEPT 2020

Commitment letter by the UR Affiliate

I VERA NKFUKFU NDIFON (Both names) from University of South Africa (Unisa), agree that University of Rwanda assigns to me the local supervisor from University of Rwanda. The Local supervisor will be involved in all steps of my research including publication where it is possible. The local supervisor will monitor daily my data collection while in Rwanda; be involved in writing the results and as actively be involved in preparing manuscripts for publication. The copy right of the study findings will remain with the University of South Africa, with which Mrs VN Ndifon is a registered Master student. Acknowledgement will be given to the University of Rwanda's support during the data collection and the participants' contributions.

I do understand and agree that I will pay any running costs that will be related to data collection monitoring/supervision by the local supervisor while in Rwanda for field work.

I also understand that I will need to submit two copies of research results at the UR Directorate of Research and Innovation at end of my research.

Sincerely,

PAID 190.000 RWF
14 SEPT 2020

UR affiliate Names: VERA NKFUKFU NDIFON signature [redacted] Dates---25/05/2020

Main supervisor (Home University) Names: Dr. HC de Swardt Signature
Date:25/05/2020

UR supervisor Signature Names: Dr Madeleine Mukeshimana-Signature: 30/06/2020

Notary
MUSHIMIRE Elode

P.O Box 4285 Kigali, Rwanda | info@ur.ac.rw | www.ur.ac.rw

Annexure 5: Participant information sheet

PARTICIPANT INFORMATION SHEET

Ethics clearance reference number: HSHDC/951/2020
Research permission reference number: N/A

Title: Supporting nursing students' clinical learning in Rwanda

Dear Prospective Participant,

My name is Vera Nkfukfu Ndifon and I am conducting research under supervision of Prof Gisela H Van Rensburg a professor in the department of Health Studies, College of Human Sciences university of South Africa, Dr HC de Swardt a senior lecturer in the College of Humanities university of South Africa, and Dr Mukeshimana Madeleine a senior lecturer , SoNM, CMHS university of Rwanda. The study is towards a Master of arts in nursing Science at the University of South Africa. We are inviting you to participat e in a study entitled: 'Supporting nursing students' clinical learning in Rwanda'

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to propose a student support plan for clinical facilitation to enhance clinical learning of nursing students registered for an undergraduate nursing programme at a selected university in the Republic of Rwanda. The proposed student support plan for clinica l training, if adopted may enhance student nurses' clinical learning and probably make a positive impact on students' learning experiences, facilitate the achievement of learning objectives, and hence improve patients' outcomes. This may facilitate the provision of safe, effective , and efficient health services to patients, hence improving patients' quality of life.

WHY AM I BEING INVITED TO PARTICIPATE?

You were specifically chosen to participate in this research study because the researcher believes that you will be able to provide the best information regarding your support needs you might have experienced while placed in the clinical field. The criteria considered were that you need be enrolled at the College of Medicine and Health Sciences of the University of Rwanda, for the four -year undergraduate nursing programme leading to registration as a nurse at the Rwamaga campus. The total number of participants will depend on data saturation. Students from their 1 st, 2 nd, 3 rd, and 4 th year, enrolled for this undergraduate nursing programme can participate in this study.

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

Permission to conduct this study was obtained from the University of Rwanda's institutional review board and the Dean of the school of Nursing and Midwifery. Contact was made with the Head of the four-year undergraduate Nursing programme. They provided the contact information of all the 1st, 2nd, 3rd, and 4th year nursing students who are currently enrolled for the undergraduate nursing programme in this campus who were purposively chosen as prospective participants.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The study will involve being part of a focus group interview. Focus group discussions would be held with volunteer participants in groups of 6 – 8 participants per group. Interview questions are semi – structured and includes questions that pertain to your clinical learning experiences. The focus group discussion will take approximately one hour thirty minutes (1hour 30minutes). The focus group discussion will be audio taped and field notes taken with your consent.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

There are no direct possible benefits for participants however the data provided by participants will assist the researcher in achieving the aim set out in the research study. Furthermore, participating in this study may provide valuable information regarding student support while placed in the clinical field in the Rwandan context. This could lead to the adoption of support plan that could enhance students' clinical learning to prepare them to become competent nurses for the provision of the best possible care to patients which may ultimately improve the quality of health services and patients' quality of life.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

The anticipated negative consequences associated with participating in this research study are:

- possible anxiety during the interview, stress when reflecting on negative clinical experiences,
- your time which the researcher requests you to set aside for the interviews which have been outlined above, and

- possible risk of exposure to covid 19 disease during focus group discussions.
  I will provide you with psychological support or refer you to the university Nurse who will counsel you free of charge if you experience any stress. I will implement all the covid 19 universal prevention measures as stipulated by the WHO and approved as public prevention measures in Rwanda to prevent you from the risk of infection with covid 19 disease during focus group discussions.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

All the information provided by you will be treated as highly confidential as far as possible and there is no need to submit your name. Although the group participants will be asked to keep the information shared in the group confidential, I will not be able to ensure full confidentiality. Information received will be strictly used for this research and thereafter the hard copies on will be kept on locked cupboards and electronic copies will be deidentified and stored on a password protected computer by the researcher for research purposes. You will at no stage be requested to complete your personal information, like name, surname address etc. Your answers will be given a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings. Your answers may be reviewed by people responsible for making sure that research is done properly, including, an external coder and the focus group assistant moderator. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records. The external coder and the focus group assistant moderator will sign a confidentially agreement.

Your anonymous data may be used for other purposes, such as a research report, journal articles and/or conference proceedings. In whatever form your supplied data may be used, your name and identity will always be kept confidential and private.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a period of five years in a locked cupboard. Electronic information will be deidentified and stored on a password protected computer with confidential passwords and a strong access control will be implemented. The antivirus software of the computer will be maintained and regular back up of the research data will be ensured. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable.
After five years the records of the data collected from you will be destroyed as follows:

- Hard copies will be shredded
- Electronic copies will be permanently destroyed from the electronic devices by reformatting.
- Audio recordings will be degaussed through a magnetic field bulk eraser.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There are no payments or incentives for participating in this research study, participation is voluntary. Furthermore, there are no foreseeable costs which will be incurred by participating in this research study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written approval from the Research Ethics Review Committee of the College of Human Studies, Unisa. A copy of the approval letter can be obtained from the researcher if you so wish. Permission to conduct this study was obtained from the University of Rwanda's institutional review board and the Dean of the school of Nursing and Midwifery.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

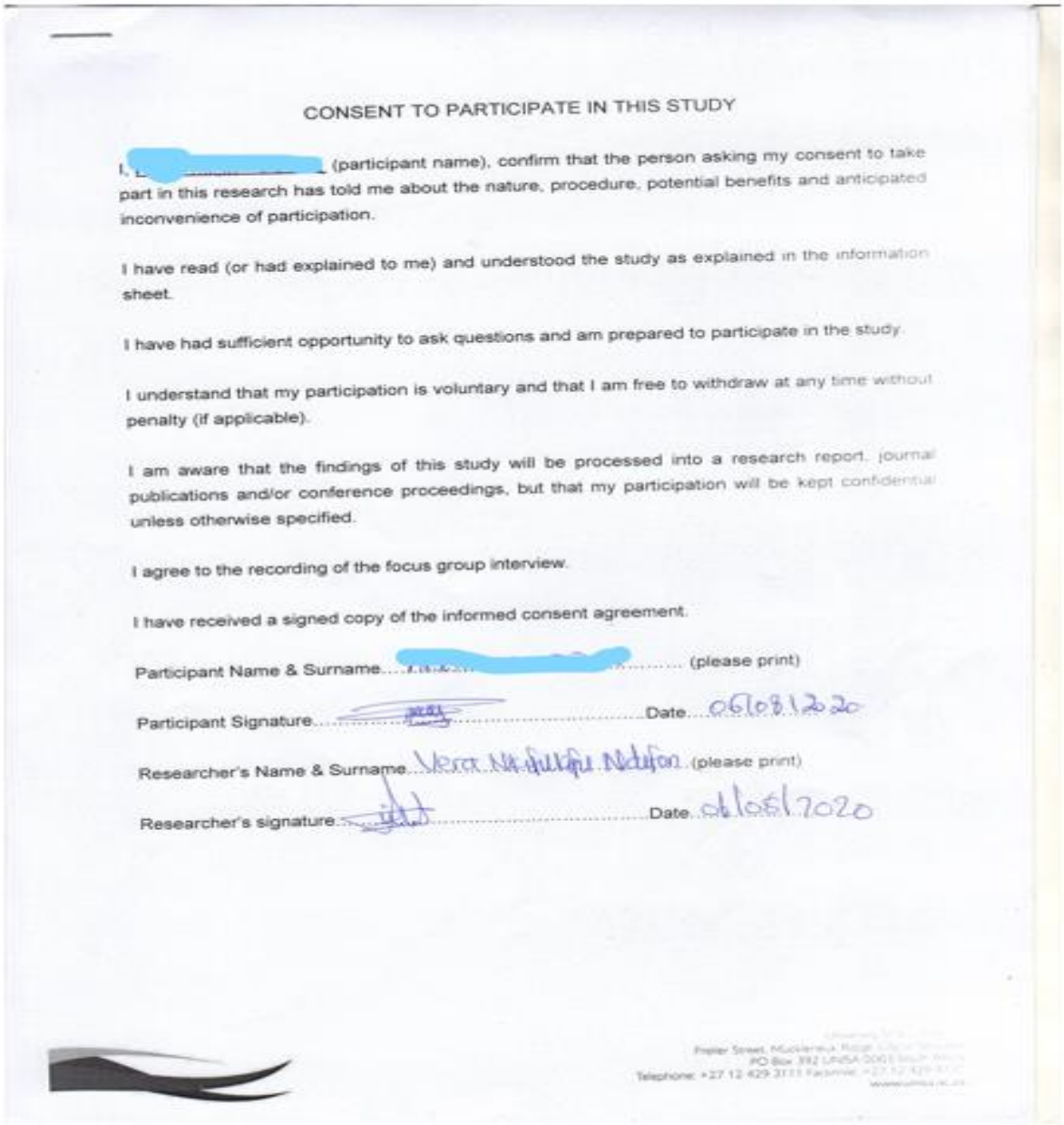
If you would like to be informed of the final research findings, please contact Vera Nkfukfu Ndifon on +250783834305 or vwndifon@gmail.com. Should you require any further information or want to contact the researcher about any aspect of this study, please contact her on the previously mentioned contact details.

Should you have concerns about the way in which the research has been conducted, you may contact Prof Gisela Van Rensburg Tel: 0124296514, vrensgh@unisa.ac.za, Dr H C de Swardt Tel: 012 429 4506, dswarhc@unisa.ac.za, or Dr Mukeshimana Madeleine Tel: +250(785256459), angemado@gmail.com. This study has been approved by the University of South Africa, Department of Health Studies Research Ethics Committee. Should you want to report any problems you have experienced in relation to the study, kindly contact Prof J Maritz, the Head of the Department of Health Studies' Ethics Committee on Tel number: +27-827888703 or E-mail: maritje@unisa.ac.za

Thank you for taking time to read this information sheet and for participating in this study.

Vera Nkfukfu Ndifon vwndifon@gmail.com

Annexure 6: Participant informed consent form



CONSENT TO PARTICIPATE IN THIS STUDY

I, [redacted] (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the focus group interview.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname [redacted] (please print)

Participant Signature ..... Date 06/08/2020

Researcher's Name & Surname Vera Ntshuxeko Ndufon (please print)

Researcher's signature ..... Date 06/08/2020

Annexure 7: Confidentiality binding form (researcher)

CONFIDENTIALITY BINDING FORM

Title of the Project: 'Supporting nursing students' clinical learning in Rwanda'

Principal Researcher: Vera Nkfukfu Ndifon

I the *researcher* understand that **I** will have access to confidential information about study site and participants. By signing this statement, **I** am indicating my understanding of my responsibilities to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study sites and participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study sites or participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information, unless specifically authorized to do so by approved protocol in response to applicable law or court order, or public health or clinical need.
- I understand that I am not to read information about study sites or participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing duties on this research project.

_____	__07/01/2019_____	Vera Nfkukfu Ndifon
Signature	Date	Printed name

Annexure 8: Confidentiality binding form (assistant focus group moderator)

CONFIDENTIALITY BINDING FORM

Title of the Project: SUPPORTING NURSING STUDENTS' CLINICAL LEARNING IN RWANDA

Principal Researcher: Vera Nkfukfu Ndifon

Assistant Moderator: [redacted]

I the assistant moderator understand that I will have access to confidential information about the study and participants. By signing this statement, I am indicating my understanding of my responsibilities to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study sites and participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study sites or participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information, unless specifically authorized to do so by approved protocol in response to applicable law or court order, or public health or clinical need.
- I understand that I am not to read information about study sites or participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing duties on this research project.

Signature [redacted] Date 15/10/2020 Printed name [redacted]

Email: [redacted]@yahoo.fr

Phone number: +25078[redacted]

Qualification: Assistant Lecturer (Masters degree)

Annexure 9: Confidentiality binding agreement/data analysis report (co-coder)

QUALITATIVE DATA ANALYSIS

MASTER OF ARTS IN NURSING SCIENCE

VERA NFKUKFU NDIFON

THIS IS TO CERTIFY THAT:

Dr Hester (Rina) Cathrina de Swardt has co-coded the following qualitative data:

Five focus group interviews

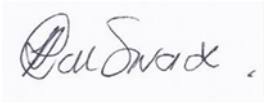
For the study

'SUPPORTING NURSING STUDENTS' CLINICAL LEARNING IN RWANDA'

I declare that the candidate and I have reached consensus on the major themes and categories and codes reflected by the data during a consensus discussion and that adequate data saturation was achieved as evidenced by the repeating themes and categories.

I agree that the shared data is to be kept confidential and that I may only discuss its contents with the researcher. Upon the student's graduation, I will remove the data from my computer and will not keep copies.

Dr HC de Swardt



HC de Swardt
D Litt et Phil: Nursing Education
5 August 2021

Rina.deswardt@gmail.com

Annexure 10: Focus group interview guide

Focus group discussion guide for Interviewing undergraduate nursing students regarding 'Supporting students nurses' clinical learning in Rwanda'

Interview session number……
Time……
Venue……
Date……
Number of participants present…….

1. Checklist

- ✓ Contact the participants by phone two weeks before the focus group discussion session.
- ✓ Send a briefing letter to the assistant moderator outlining her responsibilities two weeks to the interview.
- ✓ Call to remind the participants and the assistant moderator before each session.
- ✓ Slightly over recruit participant for every session.
- ✓ Ensure that the recording device is working and take along an extra device.
- ✓ Arrive early to make necessary arrangements of the venue before the interview session.
- ✓ Rest well to be alert for the focus group discussion.
- ✓ Check to be sure that the interview is being recorded.

2. Moderator technique

- ✓ Remain neutral.
- ✓ Deal with dominant participants.
- ✓ Make sure the participants are comfortable.
- ✓ Elicit further information from shy participants.
- ✓ Transcript the focus group discussion as soon as the discussion is completed.
- ✓ Manage challenging group dynamics.
- ✓ Avoid asking leading questions or giving personal opinion.
- ✓ Use probes.

3. Assistant moderator's responsibilities

- ✓ Assist in setting up the interview room.
- ✓ Take notes throughout the interview.
- ✓ Monitor the recording device.
- ✓ Deal with late comers.
- ✓ Ask questions if invited.
- ✓ Be prepared to give a summary at the end of the session.
- ✓ Be prepared to debrief the session with the moderator immediately after the discussion.
- ✓ Ask for anonymous feedback from participants in order to help the planning of the subsequent interview session.

4. Welcome

I want to thank you for taking the time to meet with us today. My name is Vera Ndifon and I am a student studying for a Master of Arts in Nursing Science at the university of South Africa. I am here with …… who is assisting me. We are very interested to hear your valuable comments on how you experience learning in the clinical setting.

5. Ground rules

- ✓ There are no right or wrong comments.
- ✓ Comments shared in this discussion should not be repeated to people outside of this group.
- ✓ Only one person speaks at a time.
- ✓ Feel free to excuse yourself if you wish to go outside.
- ✓ Please do not have side discussions.
- ✓ Everyone should participate.
- ✓ There is no order for participating.

Do you have any questions or concerns about what I have just explained?

6. Nursing students' interview questions

"Please share with us your clinical learning experiences about the support that you need whilst placed in the clinical area that could help with the clinical facilitation of your clinical learning and how you think your clinical placement can be enhanced?

- Possible probing questions − ***cognitive support needs***
  - Please tell me more about:
    - Your learning objectives?
    - Theory learned and how it assisted your practice?
    - The role of educators?
    - The role of mentors?
    - Learning opportunities?
    - Feedback?
    - Orientation?
    - Assessments?
    - Relevant learning resources?

- Possible probing questions – ***affective support needs***
  - What about:
    - Feeling valued?
    - Feeling confident?
    - Feeling welcomed?
    - Feeling comfortable?
    - Your self-esteem?
    - Relationship with mentors/educators?

- Possible probing questions
  - What about? – ***systemic aspects***
    - Provision of equipment?
    - Reflection of your opinion in planning of your placements?

- Organisation of your learning in the clinical area?
- Preparation prior to placements?
- Timing of placements?
- Timely communication between the university and health facility?

“Please tell us what support that will assist you best with your clinical learning?”

- Possible probing questions
  - What about online support?
  - What about discussion groups?
- Is there anything else you like to share with us about your clinical leaning experience?

[The order of the questions might change and depending on the participant responses, clarifying and following up questions might be asked.]

7. Conclusion

It has been a pleasure finding out more about your clinical learning experience and some of your life experiences. Let us briefly summarize the information that we have recorded during our interview.

8. Closing

We should have all the information we need. Will it be alright to contact you to clarify uncertainties once we have analysed the data?

Thank you again for your time.

ATTENDANCE LIST

Date:
Venue: Remera Campus

S/N	Name	Age	Gender	Institution	Tel	Email	Level of study	Ticket amount	Signature
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Annexure 11: Example of transcripts

Audio file name: FGD1_Level 4
Participant (s): 1,2,3,4,5,6,7,8
Interviewer (INT):
Also present: INT 2

INT	Thank you for making time to come and participate in this study. We'll start right away with the questions… So, this study is all about… to know your clinical learning experiences with the *(wi)* unit when you are placed in a clinical area. So, your sopo9d can be in terms of learning objectives, It could be in terms of the theories that you have learnt in school, how is it being applied in this clinical area, It could be in terms of how you feel when you are in the clinical area… are you valued, and it could also be in term of your… the administrative… Mmm… How your school plans your clinical practice, and it is going to touch all these areas. So you are just going to tell us, just talk freely, you tell u what you really need from your experience at the clinical area. I believe you've been placed in clinical areas for at least a year or two. So… participation can be in any order. You just put your hand up, and then you just say your number and you talk.	
Part. 8	Thank you, my number is eight (8), The support that we can need in our clinical learning… It is a planning… I went when I was in level 2, I went in a clinical placement in a hospital somewhere, then we found a lot of student from different universities, bsecause of poor preparation, by the time we reached there, we found more people, more students there, then our learning objective became difficult to reach. So, what I can wish in clinical placement is… the planning of… the plan of going in clinical placement should be improved. For example, when one university plans to go in October, another university already knows that this university has students in this hospital, so, we should postpone our clinical placement, in order to prevent a lot of students in one hospital. That is one challenge and support we need. Thank you.	Poor plannir Overcrowdir
Part. 4	Thank you, I am participant number 4, and my comment about the… what can be done so that the clinical placement for the students should be very good, so that the objectives of the students can be met well is that… there is a problem of a few number of supervisors. You can find that about 20 students are having only one supervisor, and they are located in many different units, some are in pediatric ward, others are in surgical ward, others are in operating rooms. So, it is very difficult for one supervisor to see what every student is doing in his clinical placement. So, my suggestion is that there can be an improvement or an increase of the number of the supervisor in clinical placements. Thank you.	Insufficient su Few numbers
Part. 3	Thank you, I am participant number 3, there is a challenge during clinical placements about exposure to blood, which can lead to HIV and Hepatitis. When you met that exposure, you buy medicine privately, by using your insurance. What we want, or what can be done is to support students after exposure in buying HIV prophylaxis. Thank you that is my view.	Lack of suppo Risk of expos
Part. 6	Thank you, I am participant number 6, the support we really need is scheduled time for the school, and for the placement we that are in. because mainly when we are in clinical placements, we meet challenges where we don't have supervisors. They are supervisors from schools, there are even nurses, and	Poor planning Overcrowding

Part. 6	Thank you, I am participant number 6, the support we really need is scheduled time for the school, and for the placement we that are in. because mainly when we are in clinical placements, we meet challenges where we don't have supervisors. They are supervisors from schools, there are even nurses, and there are also other health care providers that are supposed to help us to reach the objectives that we are planning to meet. So, when we reach there, we have a challenge where we are so many students, and the number of workers there are few, so they can't really know what we are doing. So, if he is supposed to take care of five students, so he will not mainly support them knowing what he is doing. So, what we need is that they can schedule the time for students in the clinical placement, and even from the school. Another challenge we met, is about the timing. Mainly we see there is sometimes when we go on clinical placements, and we have few times on some departments. Like we have one week one in one department or two weeks. When we reach on some departments, on week is for knowing the department, what they do, how they do it, here the material are… so, when we have few weeks on that department, like two weeks, we don't really catch all our objectives. Because we have only to weeks, and on those two weeks one is for orientation, other weeks we are making reports of that department. So… that's the challenge e meet, and where we see we can't reach on our goal.	Poor plan Overcrow Few supe Few nurse Short plac Poor achi
INT	Do you mean… when you go to a hospital, you can move to many departments, at one time you are in one department, another time you are in another department. You want to spend more time in one department before moving in another department.	
part. 6	Yeah.	Poor plan
Part. 7	I am participant number 7, the area that should be enhanced in the context of the university of Rwanda; the first thing is to always evaluate clinics we are going to spend our time in, and should always evaluate them to see if we can meet our objectives there, before we go there. There should be always an evaluation of the hospitals, because sometimes they tell you that you have to do this at that hospital, and you go, maybe there are materials you can't find there, and another point from there is that sometimes there are materials which are not very expensive to the university of Rwanda. I think if there are some hospitals which don't have some materials, they can buy those materials, we carry them to the hospitals, and maybe we can use them at our schools. But the best thing is to carry them to the hospitals if the hospitals can buy them, and if they are not very expensive.	Lack of e Poor aligr learning c Insufficie
INT	Is it the school that is responsible for getting materials for your clinical placement, or is it the hospital where you are placed?	Insufficie
Part. 7	It depends on the materials. Some we buy them ourselves, others are being given by the university. But there are others that we find at the hospital. And our hospital are not on the same level. Sometimes you will find materials at one hospital and you can't find them at another one.	
INT	So the students… are you supposed to provide the protective materials like gloves… or is it the school?	
Part. 7	It's the school.	
INT	For the protective materials.	
Part. 7	Yeah. The materials are… Let's take an example of maybe like an autoscope. Let's take that one as an example. They are going to send you to Kibagabaga hospital and after that evaluation that I have said, you will find that there is not any autoscope in the whole hospital. They can give like one autoscope for like ten to fifteen students, and they can use it for that specific field. Thank you.	
Part 8	I got another view about what my colleague just said,	

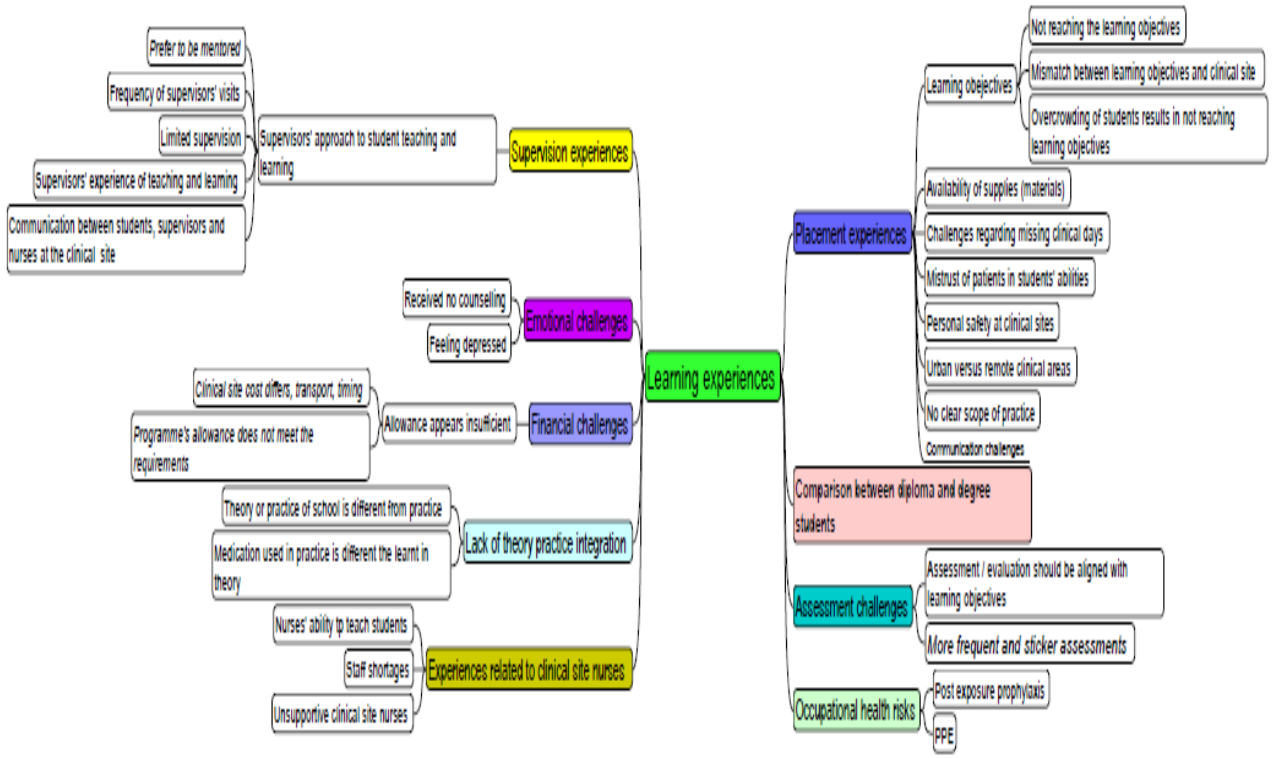
INT	Your number (Please)	
		Poor orga placemen
Part 1	Thank you, I am participant number 1, and the challenge I have observed I about organization between *(wi)* setting here those health institutions, health providers and health institution teaching… they are not well organized, and student during clinical practice, they practice differently from what they learnt. My point of view about the support is all about the organization, and if the student is supposed to follow a given number of client or patients, in that e learnt there is time. If you are going to follow for example five clients and in the hospital you make a follow up for 40 client and there is… they say you are going to practice that you have learnt I becoming different. And the organization to make supervision to the student going to clinical practice has to be improved and to make sure the student are fulfilling their objectives for a given number of patients, not totally the patients in the hospital	Theory pr Work ove
INT	So, what I understand is… are you saying there is a theory practice gap, or you are saying the students arrive there and if they were supposed to follow a few number of clients, they meet so many they have to follow?	
Part 1	I mean… At school, we learnt proper ways of managing the clients. But during clinical activities, we don't do it in proper ways because of many client we are following, because we have been taught to manage properly a few number of clients	
INT	So, you want to be treated like students at the clinical, and not as the workers.	
Part 1		Altered se
Part 5	Thank you, I am participant number 5, what I can say is; if the value given to the student in clinical setting by health providers may be enhanced could be better than before. I say this because of my experience what I have seen in health care settings here you find that student are not being valued as it should be. Here they perform their activities according to what they learnt, and according to the objective of hat they have, and you find that they are not being valued at all, where you can be afraid of performing it at all. And when we are in clinical setting, we wish to build our self-esteem in what we do, and if they are not given time to perform well together with clinical supervisors, helping them to perform build would be their self-esteem in their activities in health care settings or their activities. It better to in the hospitals. Thank you.	
INT	How do you feel not valued? You mentioned… what asp`ect of self-esteem do you really need? Can you tell us more about it?	
Part 5	What I said is… for example I am performing duty today, and one of the health providers and the patients say "What you do is not true (Correct) together with the patients, he or she doesn't take time to tell you "you have to do it like this or like that, be followed by s supervisor or someone health providers were together with, another time you are going to perform that activity, you will be afraid to do it. Thank you.	Low self Low supe
part 2	Thank you, I am participant number 2, and my point of view when we are in clinical placement, a my colleague have said, there are a few number of supervisors, and a big number of students, and my suggestion is that, for example at a hospital, or clinical setting, there should be one staff member or one worker who is in charge of the students, in order to help those supervisors to reach the students	A need fo site
INT	Okay, do you mean when you go to… do you mean someone in charge of the students who is in the clinical area, or in the school?	

Part 2	Yea, for example in schools there are few lecturers or supervisors who are being sent to the hospital, if it can be possible, there can be some staff at the hospital ho can help those supervisor because they are few to reach every student	Few numl
INT	When you are in the clinical area, are your supervisors from the school?	
Part 2	Yes.	
INT	Nobody is there with you?	
Part 2	No. for example they come like three days in a week, and other days the students are together with the staff members, they try to help us but if someone is placed as in-charge of the students, there can be an improvement.	Infrequen
INT	Like a clinical facilitator ho is based maybe at the clinics or hospital here you are placed to take care of all the students who are there?	
Part 2	Yes.	
Part 7	I am participant number 7. Another thing I think should be enhanced in the context of the university of Rwanda, there should be a strict way of evaluation. Most of our supervisors are like "when did you get to the hospital, when did you leave, have you been there…" Things like that. They should enhance in evaluation of what have you learnt on that day? I think there should be a very strict way of evaluating students. What they have got, and how was his day at the hospital. I have been with nursing students from Belgium, they had no supervisors at the hospital, and they were very strict more than us who had supervisors. They were very strict about how to report, and how to show what they accomplished. For us we were being evaluated like "when did you get to the hospital, when did you get out of the hospital, how many days have you been at the hospital?" I think they should put more emphasis on what we get from the hospital, instead of…	Poor eval Insufficie
INT	…how long have you have been there.	
Part 7	Yeah, how long we have been there.	
INT	Can you tell me more about this evaluation? You say you… does it really mean you don't get an evaluation like "What have you learnt…?"	
Part 7	Yeah, we get evaluation like… if you get many evaluation like in a 2 months period, and most of us don't get even one at the end of the clinical placement. And I think the evaluation should be very strict, and should be carried out multiple times, like 3 times in a week. That could push the students to learn more and show what they learnt.	Infrequen
INT	So, with this evaluation, when you are being evaluated, are you evaluated based on these learning objectives that you were given?	
Part 7	Yeah.	
INT	And if you are evaluated like once, during these evaluations, can they cover all these learning objectives when evaluating you?	Insufficie
Part 7	I think sometimes no.	
INT	Sometimes no.	
Part 7	Yeah, because sometimes the supervisor chooses in which service you are going to be evaluated in. and it can be in more than 3 different services. And you are chosen to be evaluated in surgery ward while you have been on many other wards.	Lack of e

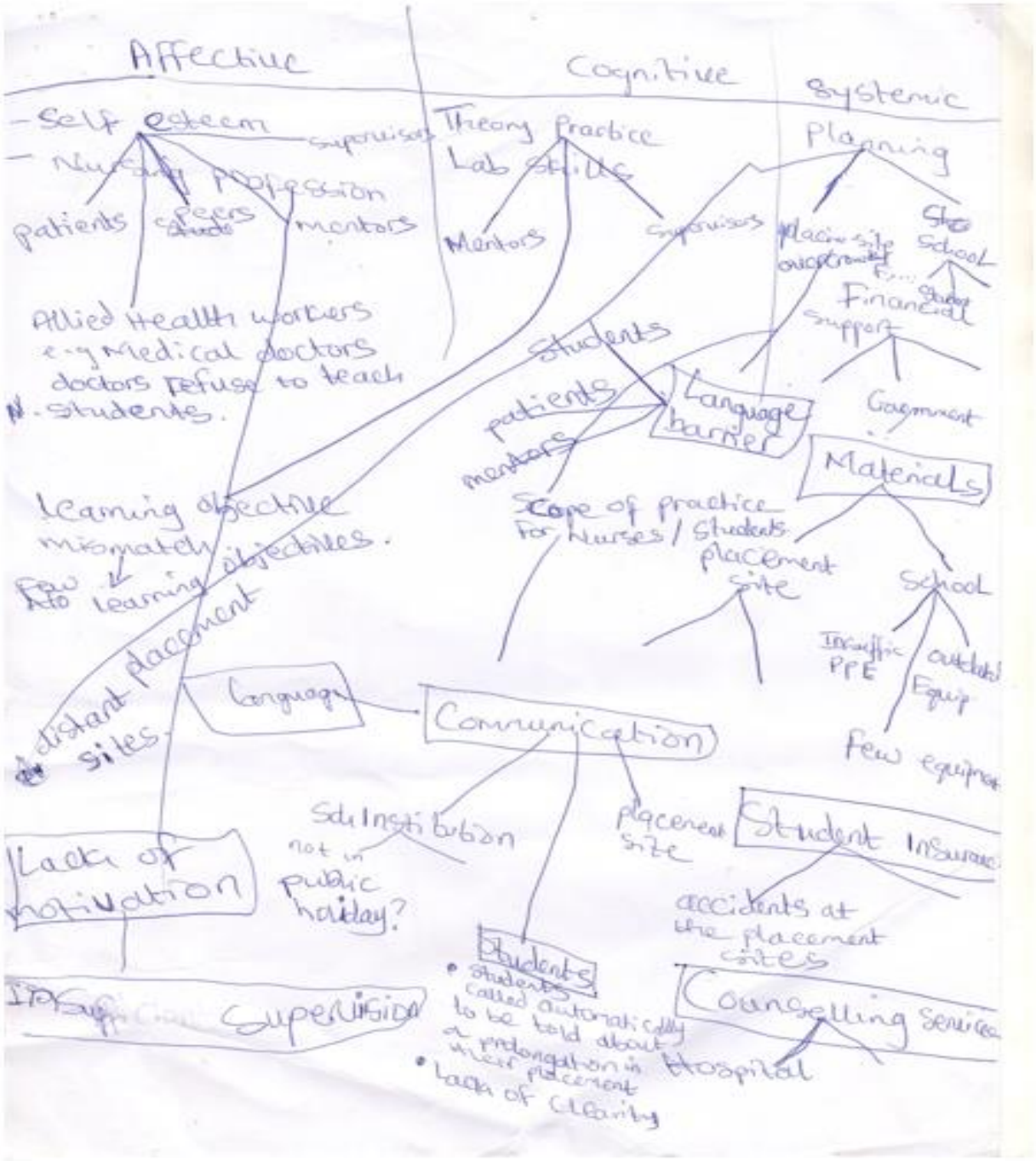
Annexure 12: Example of data analysis

	Category	Case	Text	Comment	FILE	LEVEL
	Placement suggestions					
	Support needed	FGD1_Level 4 - Forma	So, what I can wish in clinical placement is... the planning of... the plan of going in clinical placement should be improved.	Improved planning	FGD1_Level 4 - Formatted	4
	Support needed	FGD1_Level 4 - Forma	For example, when one university plans to go in October, another university already knows that this university has students in this hospital, so, we should postpone our clinical placement, in order to prevent a lot of students in one hospital. That is one challenge and support we need.	Improved planning	FGD1_Level 4 - Formatted	4
	Support needed	FGD1_Level 4 - Forma	allowing the student nurse to carry out a professional internship during their holidays or the time out when they are waiting for a job after finishing all the studies	8 - Timing of clinical placement	FGD1_Level 4 - Formatted	4
	Support needed	FGD3_Level 2 A- Forn	like long period to spend at the clinical placement and according to the objective we had or we have, they can say that this time we are going to have theory in the next time like two months or three months, according to the objective we h	Clinical placement according objectives	FGD3_Level 2 A- Formatted	
	Support needed	FGD4_Level 3 and 4- F	Because if you don't have the great supervision you find that some student will remove from the clinical placement while they didn't gain enough skills and knowledge about different practices	Remove from clinical site while	FGD4_Level 3 and 4- Forn	3
	Support needed	FGD2_Level 3 B_ Forn	My opinion was that as we made the report at final placement they must look upon them when the placement is coming back just student locate them DH that is crypt and receive many patients so that will get some knowledge about some disease and how to receive the patients as	Assess clinical site prior placement	FGD2_Level 3 B_ Formatted	
	Support needed	FGD4_Level 3 and 4- F	Yeah, for me in the fourth year if I get that chance of getting to those hospitals, but there are some colleagues who didn't get there while we are in this level four, the reason why. It's because those hospital are not enough in Rwanda, but being not enough doesn't mean that every student can access to that. If I can get in that hospital like three weeks and another one go for three.	Assess clinical site prior placement	FGD4_Level 3 and 4- Forn	3
	Support needed	FGD1_Level 4 - Forma	They have to evaluate those hospital that are going to receive those students if they have these materials so that we accomplish and help them to fulfill their objectives	Assess clinical site prior placement	FGD1_Level 4 - Formatted	4
	Support needed	FGD1_Level 4 - Forma	evaluate clinics we are going to spend our time in, and should always evaluate them to see if we can meet our objectives there, before we go there	Assess clinical site prior placement	FGD1_Level 4 - Formatted	4
	Support needed	FGD1_Level 4 - Forma	My number is 8, about the evaluation of those hospitals that student are going to do clinical placements, and for example they send you to a hospital in the western province to fulfill so clinical objectives	Assess clinical site prior placement	FGD1_Level 4 - Formatted	4
	Support needed	FGD1_Level 4 - Forma	But in that hospital they don't have some materials we need in order to fulfill your objectives. Our view is to... before you go there, they have to know if this hospital has materials that our student will need in order to fulfill their objectives,	Assess clinical site prior placement	FGD1_Level 4 - Formatted	4
	Support needed	FGD2_Level 3 B_ Forn	What we are suggesting was that as we made the report for clinical placement they must look upon those report and when the clinical placement comeback they took those students on that clinical site and translocation them on their site that is reach and access	Students to report about clinical placements s	FGD2_Level 3 B_ Formatted	
	Support needed	FGD2_Level 3 B_ Forn	So again currently in this pandemic they have introduce or they have established Google form for us to select clinical site ourselves as students but before they used to go and sit on our own feet and say this student is going to go in this clinical site and this one is going to go in this site without considering different conditions that should favor that student. When going on certain clinical sites, so the conditions over there is going to be good for him and all students come from different economic background. So this affect us so much, and I can give an advise if it can be addressed and when they are in clinical placement allocations they can be always reserving all the rights for the students to choose according to the nearby hospital, nearby clinical site, so that the student himself will be knowing that the condition will allow him or her to attend clinical and achieve all objectives. So that's all I have to say	Include students' preferences with clinical placement suggestions from students re clinical placement	FGD2_Level 3 B_ Formatted	
	Support needed	FGD3_Level 2 A- Forn	then we go back to school so that I can think that we can attend like one semester at school, then another semester on clinical placement.	Suggest a block system	FGD3_Level 2 A- Formatted	
	Support needed	FGD3_Level 2 A- Forn	the question I have or suggestion if it possible they can change the curriculum and they say this semester is for clinical placement. So we can have enough time to practice what we learn at school	Suggest a block system	FGD3_Level 2 A- Formatted	
	Support needed	FGD5_level 2, 3 and 4	Another challenge is, as I have done, many clinical placement starting from level one up to level two, we had a school calendar, which is longer than other students from the University of Rwanda. Some of the students of University of Rwanda, they have completed the year in June, others in July. But for us, we finished, I don't remember, if it is September.	School calendar	FGD5_level 2, 3 and 4 - Formatted	
	Support needed	FGD2_Level 3 B_ Forn	I found some district hospital someone who is in charge of students who are interne ship where he manage all challenge or anything the students do, as an advice I would like for advocacy to put those in all DH for the students well functioning our intern	Placement where sites are functioning well	FGD2_Level 3 B_ Formatted	
	Support needed	FGD3_Level 2 A- Forn	Maybe they can give you those two days; in week cannot after the clinical placement other at school you are still at hospital. If possible they can say if you're missing one day, you can go in the weekend and compress that, not after the clinical placement	Suggestions to replace lost clinical days	FGD3_Level 2 A- Formatted	
	Support needed	FGD3_Level 2 A- Forn	So if we had a problem, I can inform my team that i had this problem and my team leader can be there go to the supervisor and to tell him or her that I have a student who had a problem which is serious	Suggestions to replace lost clinical days	FGD3_Level 2 A- Formatted	
	Support needed	FGD3_Level 2 A- Forn	I am participant 5, for the questions, for this participant number two for the first question about the punishment given to someone who is absent. I think it's good for the students who don't want or who don't like to go there in clinical placement. There is people who don't like to go there always. But I think because we go there in team and you have a team leader, the supervisor can just like having faithful the team leader	Suggestions to replace lost clinical days	FGD3_Level 2 A- Formatted	
	Support needed	FGD1_Level 4 - Forma	Sometimes we go in clinical placement without doing practice of what we have learnt as theory in clinical practice when we are at school. So, what I want or my suggestion is to increase time for practice or before going to clinical placement in a hospital.	3 More time in preparing for preparing students prior placement	FGD1_Level 4 - Formatted	4
	Support needed	FGD3_Level 2 A- Forn	When you went there for one month, you take one week for attention and other second	More time in preparing for	FGD3_Level 2 A- Formatted	

EXPERIENCE	TEXT	COMMENT	FILE	SUPPORT NEEDED	TEXT	COMMENT	FILE
SUPERVISION	#1#that the objectives of the students can be met well is that… there is a problem of a few number of supervisors. You can find that about 20 students are having only one supervisor, and they are located in many different units, some are in pediatric ward, others are in surgical ward, others are in operating rooms. #5# We don't get much supervision as we needed, #2#, they don't reach to all students at the site, #1# So, it is very difficult for one supervisor to see what every student is doing in his clinical placement. #2# we still have the problem of small number of lecturers when they came at site to visit in clinical placement #1# in schools there are few lecturers or supervisors who are being sent to the hospital, if it can be possible, there can be some staff at the hospital ho can help those supervisor because they are few to reach every student. #4# that even supervisors are not there several times. They come once a week, two times or once a month it happened. So if they come really like that, they do not know even what you achieved. #3# Sometimes supervisors may come to the site like once in a whole month while you have a whole month to stay there and the supervisor comes twice or even one time, and the goal that makes him more hard to come is mainly doing the evaluation and saying goodbye. #1#, there are a few number of supervisors, and a big number of students, and my suggestion is that, for example at a hospital, or clinical setting,# #1#Because our supervisors can come like once in the whole period of clinical placement, and that is not a good way to supervise us. So, what I need is that the supervisors may come often, and in that often we can have time for the theory. To review the theories we have learnt in the class. Even if we are in clinical placement, we are supposed to do practice. #4# we have five days to work in clinical placement, so and we work nine hours per day. So students go home and they don't get more time to revise what they studied during the clinical placement, so when it's comes for four	Insufficient supervision. Few numbers of supervisors. Low supervisor / student ratio Insufficient supervisions. Infrequent supervision Overcrowding at placement sites. Learning objectives not met. Shortage of nurses at placement site. Conflicting priorities Poor organisation of supervision. High expectation from students. Theory practice gap. Unmet objectives.	**Audio file names:** **#1#=FGD1** **#2#= FGD2** **#3#=FGD3** **#4#=FGD4** **#5#=FGD5**	**SUPERVISION**	#1#So, my suggestion is that there can be an improvement or an increase of the number of the supervisor in clinical placements. Thank you. #2# if it can be possible they can increase the number of lecturers of nursing lecturers when they are at clinical placement or be obligated to nurses to take the teaching as their responsibility be-cause sometime you find nurses they are not care about the students. #3# it is a suggestion, a strong one, that supervision would be increased at the high level, at the high level, such that each and every student would have someone to help him or her to assist him or her in every kind of new performance that he or she does, because it is very challenging. #2#as an advice I would like for advocacy to put those(clinical facilitators) in all DH for the students well functioning our internship. Thank you. #1# there should be one staff member or one worker who is in charge of the students, in order to help those supervisors to reach the students. #, if it can be possible, there can be some staff at the hospital who can help those supervisor because they are few to reach every student.# , #4# to provide student nurses and mentorship and time to discuss what they learned and to do a follow up for if they learned pharmacology from school in theory, are their doing the same thinking in the clinical setting, because you see, you learned that amoxicilly, you learned piniciline,you learned siprofracticine and go to the setting where you find they are giving the same medication for all cases they have in word	**Need for an increased number of supervisors.** **Need to make teaching of nursing students obligatory for nurses.** **Need for clinical facilitators at placement sites.** **Need for frequent supervisions.** **Need for time to review theory during clinical placement** **Need to improve the organization of supervision.** Need for proper time scheduling at placement sites and universities to	**Audio file name: FGD1_Level 4**



Annexure 13: Example of reflexive notes



Annexure 14: Covid-19 compliance letter

COVID COMPLIANCE LETTER

TO: The Chairperson

Research ethics committee, CHS

Date: 5/08/2020

Re: COVID 19 SAFETY MEASURES DURING DATA COLLECTION

COVID 19 epidemic has affected the whole world, it is necessary that precaution be taken to prevent risk of infection during data collection for both the researcher and the participants. This letter serves to indicate measures that will be taken to protect the researcher and the participants from COVID 19 during data collection.

The researcher will use universal prevention measures for COVID 19 as stipulated by World Health Organization (WHO) and approved as public prevention measures in Rwanda:

- The researcher will avoid close contact with and between participants through implementing physical distancing. 1-meter distance will be maintained between participants.
- Participants in each focus group discussion will be limited to 7 at a given time and social distancing will be emphasized.
- The venue for focus group discussion is a university campus which already has a temperature check point at the entrance through which all participants and the researcher will pass. Should the researcher or any participant record any high temperature they will be sent for full screening and the interview will be cancelled.
- The participants will be provided with face masks or be informed to use their own if they prefer to do so. The researcher will ensure the correct use of face masks for all participants. The researcher will ensure that the room in which the focus group discussions are conducted is well ventilated. The sharing of appliances like microphones will be strongly discouraged.
- A 70 % alcohol - based sanitizer will be provided by the researcher for both the researcher and participants to sanitize hands before and after the interview. Handshakes will be strongly discouraged.
- Surfaces such as chairs and tables will be thoroughly cleaned using alcohol - based surface cleaner.

In addition to the measures the participants will be provided with a National tollfree number (114) for COVID 19 screening to call at their convenience.

Yours faithfully,

Vera Ndifon

Annexure 15: Certificate of editing

ANTHONY SPARG

Freelance language practitioner

MA *cum laude* in African Languages (isiXhosa), MA *cum laude* in Linguistics

English language editing, isiXhosa–English and Afrikaans–English translation, and transcription

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8 January 2022

To whom it may concern

ENGLISH LANGUAGE EDITING DECLARATION

I, Anthony Edward Sparg, freelance language practitioner, hereby declare that I language-edited the MA (Nursing Science) dissertation titled "A student support plan for clinical placement of nursing students in Rwanda" (excluding the reference list and annexures) for Vera Ndifon.

Thank you.

Yours sincerely

.....

Anthony Edward Sparg

Annexure 16: Turnitin report

turnitin

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

The first page of your submissions is displayed below.

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File size:	5.51M
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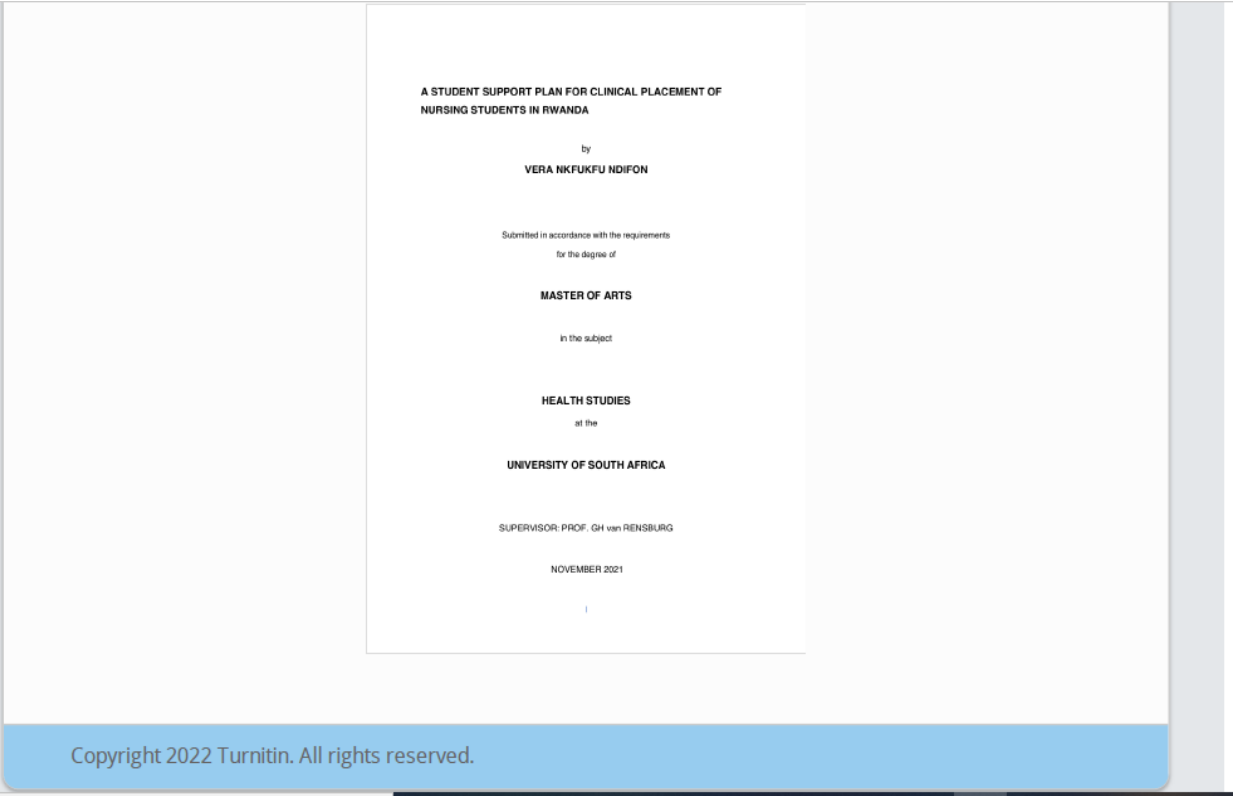

A STUDENT SUPPORT PLAN FOR CLINICAL PLACEMENT OF NURSING STUDENTS IN RWANDA

by

VERA NKFUKFU NDIFON

Submitted in accordance with the requirements for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF. GH van RENSBURG

NOVEMBER 2021

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