STUDENT NURSES' EXPERIENCE OF CLINICAL ACCOMPANIMENT IN A PUBLIC HOSPITAL IN GAUTENG PROVINCE

by

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DECLARATION

I declare that STUDENT NURSES' EXPERIENCE DURING CLINICAL ACCOMPANIMENT IN A PUBLIC HOSPITAL IN GAUTENG PROVINCE 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.

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SIGNATURE DATE

(Ms N S Mntambo)

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ABSTRACT

Clinical practice is the core of nursing education during which the student is socialized into the nursing profession. During this period, there is transfer of knowledge and skill from qualified nurses and other members of the multidisciplinary team to student nurses. The purpose of this study is to describe and explore student nurse's experiences of clinical accompaniment in a public hospital in Gauteng Province by means of a qualitative approach that included the exploratory, descriptive and contextual study. Three focus group interviews were conducted with students and one with clinical accompanists. Qualitative methods included categorizing and coding. The major findings of the research revealed that participants regarded relationships and communication as important for clinical accompaniment. Both student nurses and unit supervisors expected nurse facilitators to accompany students in clinical settings; but some hospital staff members did not perceive clinical accompaniment to be their task.

KEY CONCEPTS:

Clinical practice, clinical environment, student nurse, experiential learning, reflection, competence.

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Dedication

I dedicate this research to all the participants who volunteered to be part of this study and nursing schools and hospitals in the Gauteng Province

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CHAPTER 1

ORIENTATION TO THE STUDY

"Learning is not attained by chance; it must be sought for with ardour and attended to with diligence."

Abigail Adams

1.1 INTRODUCTION

Although philosophical theories of learning, education, training and development are frequently developed in isolation from one another, it is only through experience, learning and application that these theories can be understood and appreciated as a unified whole (Beard & Wilson 2002:13). Learning from experience is a fundamentally important and natural mode of learning because it gives a learner personal opportunities to reflect on what he or she has been told and to make the learning an integral part of his or her experience. It is one thing to be given information and to be instructed in techniques and methods. But it is another thing to integrate that knowledge with all one's previous experience and understanding so that the information that one has received becomes truly personal. Sometimes what passes as "learning" is ineffectual because learners simply do not have enough time to reflect on what they have been told or because they have few opportunities to associate with those who would be able to act as their guides or mentors (Beard & Wilson 2002:13).

Cross and Israelit (2000:313) assert that learning from experience or *experiential learning* gives one a "holistic integrative perspective on learning that combines experience, perception, cognition, and behavior". This understanding informs the models of learning that were constructed by Lewin, Dewey and Piaget. Innes (2004:17) notes, for example, that one of the basic principles of constructivism is that the acquisition of new knowledge is strongly influenced by the prior knowledge and experience of the learner. It has been observed that

learners can be strongly resistant to the acceptance of new learning unless the views that are presented to them are sympathetically and carefully clarified and explained. The reason why this happens is that human beings tend unconsciously to protect their intellectual and personal integrity by being loyal to their established opinions, attitudes and worldviews including any form of new information to which they are exposed as the potential of undermining their established prejudices and attitudes. While some forms of information will not constitute a threat to learners, other forms of information (such as, for example, new religious, ideological or political ideas) may make learners feel intensely uncomfortable or even hostile. This is one of the problems with which teachers and instructors of all kinds have to cope.

The World Health Organization (WHO 2001:77) asserts that "the performance of health care systems depends ultimately on the knowledge, skills and motivation of the people responsible for delivering health care". The statement is also applicable to student nurses because the acquisition of new forms of knowledge and learning and the mastery of new skills – as well as the acquisition of a variety of motivations that are basic to their professional integrity – constitute the foundations on which their clinical training is constructed. The absence of such factors in the training of student nurses will result in inadequately prepared professionals who will produce sub-standard work – often at the expense of the welfare (or even the lives) of the patients who are entrusted to their care.

Cody (2006:73) argues that student nurses are regarded as scholars in the nursing profession. Being a scholar implies that the person concerned attends a school and follows the course of studies under the guidance of a mentor or a teacher. Cody (2006:74) adds that the nurse scholars of the 21st century should have the capacity to assimilate nursing theories and the conceptual frameworks that inform these theories. The author also notes that nurses who are scholars should be able to utilise the theoretical frameworks that are available in nursing science to enhance their practice, to conduct research, to suggest new trends for the benefit of nursing education, and to compile regulations that will function as guarantees of the professional integrity and conduct of those in the profession.

Kincheloe (2005:9-10) points out that one of the axioms of the constructivist theory is that "different individuals coming from diverse backgrounds will view

the world in different ways". Constructivists (and other theorists) also note that the human mind actually constructs what it is accustomed to seeing and that it unconsciously makes what it constructs in this way to appear as objective. One of the corollaries of this theory is that knowledge that has already been acquired may, under certain circumstances, be changed and interpreted in other ways in practice.

In South Africa, the Scope of Practice that is outlined in Regulation R. 2598 of 30 November 1984 (Regulation R2598, 1984, Paragraph 6) emphasises that the competencies that are expected of more junior nurses, including student nurses, need to be practised under the direct or indirect supervision of a registered nurse.

According to Beard and Wilson (2002:8), *experience* is a synonym for *learning*. If they are correct, there must be a formal connection (both philosophically and in practice) between formal and experiential learning. These authors also point out that the ultimate purpose of the experiential learning that is acquired during clinical practice is to help the student nurse to cope with the exigencies of the real world and to create an environment that is conducive to the processes of further learning.

If clinical knowledge and skills are to be maintained at the highest possible level, all nurses, including student nurses, need to expose themselves to continuous professional development. Manson, Fletcher, McCormick, Perrin and Rigby (2005:427) are of the opinion that continuous professional development will entail both knowledge and/or skills – depending on the individual needs of the nurse practitioner and the areas in which she or he is deficient. The updating of skills and the maintenance of knowledge are both necessary to ensure a consistently high standard of good-quality patient care. This is especially important in professions such as nursing in which the development of practical and theoretical knowledge never remains static. The student nurse must therefore be open to the acquisition of new knowledge and skills, and, in some cases, be prepared to adopt new attitudes and values (Tabriz University of Medical Sciences 2002:1). This kind of openness and willingness to appreciate changing circumstances and values often goes against the grain of our innate

human epistemological conservatism. The South African Nursing Council (SANC) states that all nurse practitioners *should conduct their practice on a scientific base* (Regulation R 2598, 1984, Paragraph 6). This can only be achieved if nurse practitioners are willing to be exposed to continuous professional development.

Experiential learning is one of the foundations of adult education. It is often adopted as a guiding paradigm in the education of adults (Malinen 2000:15). The epistemological assumption behind constructivist experiential learning is that knowledge is acquired by means of a set of personal assumptions about how the world works. Such an assumption is central to the constructivist's definition of learning (Malinen 2000:49) and to the understanding of what "experiential learning" means.

The ability to provide quality health care depends on the philosophical assumptions and the methods that have been installed in aspirant student nurses during their training. Since all health care systems are labour intensive, they require properly trained , well qualified and experienced nurse practitioners to produce optimal results (WHO 2001:77). Since those who train student nurses are the ultimate custodians of the standards and quality of the nursing profession, they also function as the mentors of those whom they teach. It is therefore their responsibility to keep a careful watch on the socialisation of student nurses and to ask themselves whether the nurses they are producing are capable of maintaining the professional standards of the nursing profession (Uys 2000:79). The acquisition of the skills required for successful practice and learning can only be accomplished when student nurses are supported and guided by their superiors in their learning environments.

According to West, Clark and Jasper (2007:2-3), there was a seismic shift during the 1990s in the educational strategies that were being used to train and educate student nurses. This shift was based on the belief that academics and professional practitioners needed to be more active in supporting their students in the overall educational process to which their students were being subjected. This resulted in an educational paradigm in which student nurses were given much more guidance during the processes of experiential learning than they had received in earlier decades and since the inception of nursing as a profession. It

also meant that there was a far greater correlation between what students were being taught by academics in the classroom and what they were expected to practice in clinical situations under the supervision of professional clinical teachers.

Motlhale (1999:5) points are that the concept of accompaniment of the student nurse was introduced in the early eighties of the 20th century in order to bridge the gap between the theory that was being learned in the classroom and the actual practices in which student nurses were expected to be proficient before they graduated as fully qualified nurses. “Accompaniment of students means to escort, attend, guide and to coexist” (Motlhale 1999:5). Motlhale devised techniques and guidelines for the effective accompaniment of student nurses which she described under five main headings that she called “dimensions”. These guidelines are set out in table 1.1 and are described in much greater detail in chapter 2.

Table 1.1 Guidelines for effective accompaniment

Five dimensions	The fifteen guidelines of effective accompaniment
Accompaniment needs	Regard each student as a unique individual. Encourage a positive attitude towards learning in each student. Make use of reflective teaching strategies, and provide continuous in-service training programmes.
Involvement in curriculum planning	Ensure that students (and field staff in particular) become involved in curriculum planning. Make certain that objectives are explicitly and clearly defined – rather than merely implied. Interact with each student holistically (take a close interest in the physical, mental and social aspects of each student’s personality and development). Make sure that students are able to apply all theory that is learned in the classroom in practice. Take care to standardise all procedures so as to avoid confusion and uncertainty. Respect and encourage modes of mutual (two-way communication) between students and their teachers.
Learning environment	Construct a safe and adequately equipped clinical learning environment that will be conducive to successful and enduring learning. Ensure that all student nurses are properly orientated to their clinical situation.

Five dimensions	The fifteen guidelines of effective accompaniment
Supervision of students	Facilitate assessments and appraisals of the practical performance of nursing techniques and methods. Regard yourself as a role model and mentor for your students. Provide continuous supervision and ensure that students always have access to you when they need assistance, guidance and advice.
Evaluation	Create the necessary conditions for formative and summative evaluations.

(Source: Adapted from Motlhale 1999:2)

These guidelines are discussed in detail in section 2.9 of chapter 2.

1.2 BACKGROUND TO THE STUDY AND PROBLEM STATEMENT

The researcher's main purpose in undertaking this research was to conduct a critical investigation and examination of the experience of clinical accompaniment on the part of a representative sample of student nurses in a hospital to which they had been assigned for their clinical practice. By undertaking such an investigation, the researcher hoped to make visible to critical scrutiny various significant dimensions of the experience of these student nurses that would normally have remained obscure and unnoticed. It is part of the training of student nurses that they are required to spend many hours within clinical settings in order to learn and develop their professional skills and identity. Student nurses who have been exposed to all the theoretical aspects of nursing in a nursing school often see a vastly different side of the nurse's day-to-day experience in their clinical setting.

Professional clinical facilitators are appointed to training hospitals to ensure that nurses become proficient in the clinical aspects of nursing science since nursing is a profession that is squarely based on both theory (knowledge) and practice (the ability to put what has been learned into practice in clinical situations). These clinical facilitators are also expected to be able to accompany and mentor students and supply them with the theoretical and practical guidance that will support their experiential learning so that they will become sufficiently confident in their future clinical settings to function as efficient and highly regarded health care professionals. It is also the purpose of clinical facilitators to demonstrate exactly how the practice of nursing can be a highly rewarding and satisfying experience. Another function of clinical facilitators is to moderate and facilitate

the contact the student nurses have with the members of multidisciplinary health care teams and other professionals who are not nurses but whose skills are indispensable for the well-being of the patients under their care.

In a study of evidence-based practice as it relates to health care professionals, Pearson, Field and Jordan (2006:1-2) reported that health care professionals are expected to be able to work harmoniously and efficiently with other members of a multidisciplinary team for the purpose of delivering comprehensive health care services to their patients. It has been demonstrated that student nurses often learn things from the members of the multidisciplinary team that are not always consistent with what they have learned in nursing school or during clinical accompaniment.

The researcher prepared herself for this study by conducting an informal analysis of the needs of student nurses during her ward rounds as an area manager in a hospital in which different grades of student nurses had been placed in order to acquire the necessary clinical experience that is mandated by the South African Nursing Council (SANC) in terms of the Nursing Act of 1978 [South Africa 1978:16(23)] – requirements that have been confirmed by the South African Qualifications Authority Act (SAQA) (South Africa 1995:5).The purpose of this informal investigation and analysis undertaken by the researcher was to gather information about the quality of exposure that was being offered to student nurses by the clinical teaching department of the hospital. In the process of undertaking this informal investigation, the researcher was also able to acquire a great deal of useful preliminary information about the experiences and opinions of student nurses as they were accompanied in the clinical setting by their clinical facilitators. It was the opinion of the researcher that the information that she accumulated by means of this preliminary investigation could lead to a framework for a formal study that would suggest the implementation of new and additional strategies on the part of the management and the nursing departments of the hospital that would enhance the experiential learning and clinical accompaniment experiences of the student nurses who were entrusted to their care. The researcher was also of the opinion that the quality of student accompaniment could be enhanced and improved. One of the results of the preliminary investigation was that the researcher also became convinced that

more information about the actual experiences of clinical accompaniment might well result in the creation of a hospital management tool that could add value to the organisation's culture and overall efficiency and effectiveness. For the purpose of this research, the researcher divided the research questions into three parts that are consistent with the three phases of the research described in this study.

The researcher arranged sessions in which she asked the student nurses to express their opinions about what they needed in order to improve the clinical or experiential learning process to which they were being subjected in the hospital. The purpose of these informal preliminary discussions was to obtain indications of those aspects of what could be improved in clinical training, and what particular aspects of their clinical accompaniment the students would like their clinical facilitators to emphasise during the process of clinical accompaniment. While the sample of students who were consulted expressed various concerns, they were unable (or reluctant) to identify and articulate their own learning needs, deficiencies and experiences. Because of this, they focused predominantly on the learning needs and experiences of nurse practitioners other than themselves. When the researcher reflected on his experiences and information that was gathered from the students, she came to the conclusion that students might have been unable (or reluctant) to identify their own learning needs and experiences during clinical accompaniment or else that they might have been oblivious and ignorant of the central importance of experiential learning in the training of student nurses.

The researcher approached these student nurses as adult learners who had, during their clinical placement in various wards, accumulated knowledge and skills by means of experiential learning. The researcher concurs with the opinion of Boud and Griffin (1987:19) who assert that when adult learners are able to express and articulate their own experiences (whether such experiences are negative or positive); they will become more enthusiastic and motivated in their attitude towards their own professional development and training.

In January 2009 the researcher therefore embarked on an extensive online search for information about clinical accompaniment and experiential learning as

it applies to student and professional nurses. The researcher performed searches on the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database and the Blackwell Synergy platform because these databases contain an accumulation of the latest versions of available nursing literature and other health and medical information that is pertinent to the nursing profession. The key words that the researcher used for these searches included: *reflection*, *assessment in clinical accompaniment, clinical accompaniment, experiential learning*. The words *mentoring* and *guidance* were also used in the searches because they are synonyms of *accompaniment* in the context of nursing education. The results of all these searches indicated that there is a lack of research and other information in the area defined by the phrase *the clinical accompaniment of student nurses* (Cise, Wilson & Thie 2004:148; Hanley & Higgins 2004:276; Seldomridge & Walsh 2006:134).

Once the researcher became aware that there were deficiencies in information about the needs of student nurses in clinical accompaniment and in clinical experiential learning, she engaged in a series of conversations with a number of clinical facilitators of student nurses because she wanted to find out what the clinical facilitators' personal perceptions were with regard to the student nurses' experiences of clinical accompaniment. The researcher therefore contacted six clinical facilitators through a process of networking – as recommended by Polit and Beck (2006:262). The identities of the clinical facilitators will not be divulged during the course of this study. The researcher then proceeded to ask the clinical facilitators whom she had contacted about their own personal understanding and appreciation of the experience of student nurses in the process of clinical accompaniment, and whether they had ever considered asking their students what they expected or needed during clinical accompaniment.

What she found out was that none of the clinical facilitators had ever actually asked the students about their experiences and expectations in the clinical field during the processes of clinical accompaniment. All six clinical facilitators did, however, indicate that there was a definite need for formal research in order to assess, evaluate and understand the experiences of student nurses so that nursing administrators and educators would be able to reflect more accurately and scientifically on what could be done to improve the quality of the clinical

accompaniment of students in clinical settings. These opinions are entirely consistent with those of Grossman (2007:34-35), who states that clinical accompanists should engage in conversations with students so that they can canvass their views about the quality of clinical experiences to which they, as student nurses, are exposed when they are placed in hospitals in order to gain clinical experience. Grossman (2007:34-35) also points out that such information is urgently needed in order to evaluate the congruence and utility of current mentoring practices in nursing education.

Student nurses spend most of their training period (a period of approximately eight months in every year) in some or other clinical environment. They are required to attend college for theoretical and academic studies for three months of each year, and also given one month of leave during each year of their training. The South African government has authorised a curriculum in terms of Section 31 (1) of the Nursing Act 33 of 2005 that prescribes how student nurses will fulfil prescribed education and training requirements. Maximum clinical experience is gained by student nurses who are placed by colleges in real-life settings under the supervision of qualified and experienced senior nurses. This is done so that experienced nurses, medical staff and nurse educators will have opportunities to "train and educate health care providers or health workers in the Republic, to make up the deficit in respect of scarce skills, expertise and competencies" (South Africa 2004:29).

1.3 DESCRIPTION OF THE CONTEXT

In this section, the researcher will introduce and describe the context in which this study took place. This description will illuminate the problem statement that follows, and will specifically mention the various ethical issues and possibilities of professional misconduct to which student nurses are exposed or to which they themselves might contribute during their experience of clinical accompaniment and guidance in the clinical setting.

The researcher conducted her study in a Level 2 provincial hospital that was situated in the Ekurhuleni district of the Gauteng Province of the Republic of South Africa. Figure 1.1 shows the area in which this hospital is situated.

Figure 1.1: Map of the district in which the hospital is situated

(Source: Gauteng Map Search 2008:1)

The map portrayed in figure 1.1 shows some of the districts of Gauteng province to which student nurses are continuously allocated for their experiential training. The nursing colleges also appoint clinical facilitators in the various hospitals whose duty it is to accompany the student nurses in their clinical practice. The South African National Defence Force (SANDF) and a few other accredited private nursing schools also utilise the provincial hospitals for student nurses' experiential learning.

The hospital in which the study was performed was a level 2 regional hospital with 310 approved beds situated in Ekurhuleni, which is adjacent to the municipal boundaries of Brakpan, Springs and Benoni. This hospital employs 100 professional nurses, 68 enrolled nurses, 76 enrolled nursing assistants, 11 community service doctors and 15 permanent medical practitioners. The hospital also employs three social workers, two dieticians, two physiotherapists, one

occupational therapist, a number of pharmacists and a large number of administrative staff according to provisions that have been approved for a hospital of this size and importance (Far East Rand Hospital Services 2009:1-2).

The brochure that describes the services provided by the hospital indicates that the hospital was initially erected in the late 1800s and was allocated to cater exclusively for the needs of the "white" community in adjacent towns and districts while the nearby Pollack Park Hospital was built to cater for all those people who were being defined as "black" people in terms of the racist ideologies that have prevailed for centuries in South Africa and that were formalised in terms of legislation by the exclusively "white" National Party between 1948 and 1994. In those years, the capacity of the hospital in which this study was performed was limited, and it functioned as a semi-private hospital although it was, in fact, a government financed and sponsored facility. In due course, because of the quality of its services and its superior resources, it also served as a referral hospital for all types of cases that needed more specialised care from neighbouring hospitals and clinics.

This hospital was then authorised to provide health services for members of all racial groups of South Africa after the first South African democratic election in 1994. This newly acquired status as a non-racist hospital was re-endorsed by the National Health Act of South Africa (South Africa 2004:2). This hospital is faces with an increased demand for its health services from the surrounding communities, the numbers of which have expanded vastly since it was built.

In a speech delivered on the 16th September 2004 at the Pretoria Academic hospital, the Minister of Health, Dr Manto Tshabalala-Msimang, announced the implementation of the recommendations to review the role and responsibility of national, provincial and district health authorities, the appointment and assessment procedures for the chief executive offices (CEOs) and general managers of all hospitals, and a number of other measures that were designed to transform the health services of South Africa, to improve infrastructure and to manage capacity of hospitals through what she referred to as "the hospital revitalisation process". This hospital, in which the researcher performed the study, was also one of the 249 hospitals that were listed by the minister in a

survey of hospitals that had been targeted for revitalisation (Creamer Media 2004:1).

The hospital currently provides the following services: a 24-hour casualty service, a polyclinic that operates during the day throughout the year, a paediatric ward, an obstetrics and gynaecology ward, four medical wards, two surgical wards, an intensive care unit (ICU), a neonatal high care unit, an antenatal clinic, a Kangaroo Mother Care unit, a comprehensive care management and treatment (CCMT) clinic for HIV & AIDS, TB & STI patients, a gateway and triage clinic, a pharmacy, units for social work, physiotherapy and occupational therapy, a post-exposure prophylaxis (PEP) clinic, theatres, and a termination of pregnancy clinic. There is also a laundry and a mortuary on the hospital's premises. The hospital also maintains a blood bank and an on-site laboratory service.

Each ward accommodates 30 beds. The wards are divided into two male medical wards that admit male psychiatric patients for an initial 72-hour period of observation and stabilisation. The two medical wards for female patients (each of which contains 30 beds) admit female psychiatric clients on the same basis as the above-mentioned two male medical wards for psychiatric patients. Each surgical ward, one for males and one for females, contains 30 beds each. The male surgical ward admits surgical, orthopaedic and urology patients while the female surgical ward admits medical, surgical and gynaecology patients. The capacity of the hospital is often inadequate for the number of patients who need to be admitted for treatment. Those patients, who cannot immediately be admitted to beds in an appropriate ward, are kept in casualty or are transferred to other hospitals (South Africa 2004:Par. 44). The paediatric ward admits all children under the age of 13 years and sometimes also small (underdeveloped) 14 year olds. The ICU unit admits both adults and children and both males and females.

Three main colleges allocate students for clinical accompaniment to the hospital in which the researcher performed her study. The grades of student nurses who are admitted to the hospital range from pupil nurses (implying nurses who have not yet completed all those courses that are necessary for official registration

with SANC), nurses who are engaged in bridging courses, primary health care practitioners, and nurses who are enrolled for courses that will lead to their registration as midwives. The main number of applications come from the local provincial nursing college which allocates students for the comprehensive four-year programme that that takes nurses through level 1 (in their first year) to level 4 (in their fourth year). On average, this college allocates about 50 students and 4 clinical facilitators per annum. The four clinical facilitators also observe the progress of other student nurses in other hospitals according to a predetermined schedule. The military college allocates up to 16 midwifery students per annum, but these are not accompanied by qualified clinical specialists. The third school is a private nursing school that allocates 30 pupils and two clinical facilitators each year.

Over a number of years, the hospital has experienced its share of negative media comments that have arisen from the complaints of customers and clients who have criticised the standard of care that is given to patients who access health care in the hospital. Some of these complaints originate from the Department of Health's Complaints Directorate. These complaints are collected from a toll-free communication system that channels the complaints to the Department of Health's quality assurance directorate.

There are also cases of professional misconduct that have been laid against student nurses, and these had been duly filed and processed by the SANC in terms of their procedures and protocols. In many cases, the SANC has taken disciplinary action against student nurses for what it terms *unprofessional conduct*. This is conduct that brings the profession and their employers into disrepute. In spite of such negative experiences, numerous compliments and expressions of gratitude have been received from patients, their families and from the various communities that the hospital serves for the good quality of care that patients have received during their stay and treatments in the hospital. In all these instances, student nurses have also formed part of the multidisciplinary teams that have been involved in the care and treatment of patients, the support of their families, and in the outreach projects that have been implemented for the benefit of the community at large. It is inevitable that there will always be those who are either satisfied or dissatisfied with the

services and treatments that they have received from the hospital, and all such reactions need to be treated (and responded to) on a case-by-case basis.

1.4 PROBLEM STATEMENT

From this introduction, the background and description of the context in which this research was conducted, the researcher was able to formulate the central problem statement of the research. The researcher was able to identify a variety of negative experiences and dissatisfactions experienced by student nurses who had been placed in this hospital for the acquisition of experiential learning during their process of accompaniment. The researcher was able to acquire an intimate understanding of the substance and context of these complaints during informal ward round because she had temporarily assumed the role of a nurse manager in the hospital. This assisted her to acquire the essential information that she needed in order to undertake this study.

As noted in section 1.3, there were occasions on which student nurses were found guilty of disgraceful misconduct in terms of the SANC guidelines and regulations about appropriate professional behaviour, and these students were accordingly disciplined and penalised because of such behaviour. The perceptions that student nurses had of their experiences during clinical accompaniment in a hospital might be influenced by their own feelings and emotions and by their own past personal experiences and encounters (Sieloff & Frey 2007:167). What the researcher was, however, mainly interested in was the extent to which the ineffectual mentoring and guidance of student nurses during clinical accompaniment had influenced their perceptions and experiences – and to what extent this might be true. This was the ultimate question in which the researcher was interested, and for which she designed and undertook this study.

1.5 AIM OF THE STUDY

The overall aim of this study was to identify and explore the nature and significance of the experiences that student nurses had during the periods of

clinical accompaniment they received in a selected public hospital in the Gauteng province in South Africa by means of a qualitative research design.
Welman, Kruger and Mitchell (2007:8) assert that the aims of qualitative research are:

- to establish the socially constructed nature of particular reality
- to deconstruct the nature of the relationship between the researcher and the object of study
- to understand and appreciate the value-laden nature of any enquiry

Any form of qualitative research implies that the processes and meanings are not rigorously examined or measured in terms of quantity, amount, intensity and frequency. Qualitative research does not rely on quantification as its ultimate goal and purpose. It is essentially non-numeric because it sets out to understand and appreciate the essential *meaning* of the subjective data that is produced ("constructed") by the minds and perceptions of those respondents or interviewees who participate in it.

1.6 RESEARCH QUESTIONS AND OBJECTIVES

According to Munhall (2001:67-68), qualitative research may be described as holistic in its approach to human beings because it focuses strongly on the human experience, realities and attitudes of people as they go about their work or play in their natural work or domestic environments. Brink, Van Der Wal and Van Rensburg (2006:80) state that writers often refer to research questions and objectives as "questions" while other authorities regard "research questions" as being synonymous with "research problems". Hill and Howlett (2005:101) describe objective information as data that can be verified and interpreted in terms of signs.

For the purpose of this research, the researcher divided the research questions into three phases, each of which is consistent with the phases of the research described in table 1.2.

Table 1.2 Layout of the phases, research questions, objectives and methodology of the research

PHASE	RESEARCH QUESTION	RESEARCH OBJECTIVES	METHODOLOGY
Phase 1:	**Steps 1** What opinions do student nurses entertain about their experiences during clinical accompaniment in a selected hospital?	To explore the views and opinions that student nurses entertain about their experiences during clinical accompaniment in a selected hospital.	The researcher divided all the participating groups of student nurses into three different groups for the purpose of focus group interviews in three different sessions.
	Step 2 What are clinical facilitators' opinions about the student nurses to whom the clinical facilitators provide clinical accompaniment in a selected hospital?	To explore the views and opinions that the clinical facilitators have about the student nurses' experiences during their clinical accompaniment in a selected hospital.	The researcher arranged for a separate focus group interview of the clinical facilitators who had been allocated to the hospital under study.
Phase 2:	**Step 1** What recommendations do the students make about their experiences during clinical accompaniment in a selected hospital?	To describe the recommendations that student nurses make with regard to their clinical accompaniment in a selected hospital.	At the end of each focus group interview session, the participants were invited to make recommendations about how the clinical accompaniment they had experienced could be improved.
	Step 2 What recommendations do the clinical facilitators make about the experiences of student nurses during their clinical accompaniment in a selected hospital?	To describe the recommendations that clinical facilitators make about the experiences of student nurses during their clinical accompaniment in a selected hospital.	At the end of the focus group interview session, the clinical facilitators were invited to make recommendations about how the clinical accompaniment of student nurses could be improved in the hospital selected for the study.
Phase 3:	**Step 1** What expectations do student nurses have about the role of clinical facilitators during clinical accompaniment?	To explore, describe and identify the expectations that student nurses have of clinical facilitators during clinical accompaniment.	During the focus group interviews, the researcher facilitated a discussion about the expectations that all participants had about clinical accompaniment.
	Step 2 What recommendations can the researcher make about the development of a tool that will be able to serve as a guide during the clinical accompaniment of student nurses in a selected hospital?	To make recommendations about the development of a tool that will be able to serve as a guide during the clinical accompaniment of student nurses in a selected hospital.	All of the focus groups were invited to give input and make recommendations for the development of guidelines that would facilitate and improve the quality of the clinical accompaniment of student nurses in the hospital selected for the study.

1.7 FRAME OF REFERENCE

The frame of reference of a study can be described in terms of its paradigm, assumptions and conceptual definitions (Polit & Beck 2006:155).

1.7.1 Paradigm

The purpose of this discussion is to outline the *paradigm* that informs this study. The researcher used this paradigm as a basis on which to construct a framework to enable the process of formulating improved guidelines for the clinical accompaniment of the student nurses in a selected public hospital.

According to Neuman (2007:41), a paradigm is "an integrated set of assumptions, beliefs, models of doing good research and techniques for gathering and analysing data. It organises core ideas, theoretical frameworks and research methods."

The South African *Concise Oxford Dictionary* (2007:844) defines a *paradigm* as follows: "A fundamental change in approach or underlying assumptions. A typical example, pattern or model of something or a conceptual model underlying the theories and practice of a scientific subject." Polit and Beck (2006:506) define *paradigm* as a "*way of looking at natural phenomena that encompasses a set of philosophical assumptions and that guides one's approach to inquiry"*.

This research was based on the paradigm of constructivism. *Constructivism* is an umbrella term that embraces radical constructivism, social constructivism, socio-cultural approaches and emancipatory constructivism (Gravett 2001:18). These various types of constructivism support the assumption "that learning is a process of constructing meaning" (Gravett 2001:18). Every person perceives, understands and interprets all new forms of knowledge and skill through the lens of their existing frames of reference. Our existing knowledge and experience therefore play a vital role in the interpretation and absorption or new forms of information (Kinsella 2006:278). Such new information is often encountered as one of the outcomes of a particular individual process or as a result of intentional collaboration with other people (Gravett 2001:19).

According to Atherton (2005:2), constructivism is a philosophy of learning that is based on the principle that reflection on one's own experiences lead people to construct their idiosyncratic and individual understanding of the world in which they find themselves. Reflection is also a process of "reconstructing and reorganising" previous assumptions and experiences so that they can be understood in the original way in which they were understood and experienced (Rodgers 2002:848). This author affirms that this kind of "reconstructing and reorganising" (Rodgers 2002:846) allows people to make sense of any new experience by interpreting it on the basis of their previous experiences and prior knowledge of the world.

1.7.2 Assumptions

Leedy and Ormrod (2005:5) assert that *assumptions* are "self–evident truths" or – more accurately – statements or axioms, the truth of which is self evident to those who hold them (regardless of their objective status, meaning or truth value). Since all research is inevitably based on assumptions, it is vitally important for all researchers explicitly to clarify their own assumptions so that the reader or observer can understand the basis on which the research is being conducted.

1.7.2.1 Ontological assumptions

Ontological assumptions allow the researcher to state whether the social reality that he or she is describing should be understood from the outside or by means of the words, thoughts and arguments that the researcher creates in his or her own individual mind (Maree 2008:31). These two positions are referred to as the "realistic" position (which claims to be objective in nature), and the "nominalist" position (which claims to be able to create significant truths from the use of words and arguments alone).

According to De Vos (2001:247), *ontological constructivists* assume that reality can be only understood and known by those who experience it directly. This implies that researchers are not in a position to arrive at the truth of any matter by themselves, but that the truth of a particular investigation or set of

statements can only be discovered in partnership with those who participate in the study. It is the aim of qualitative researchers to discover and elucidate the meanings that people attach to a specific situation. De Vos (2001:242) notes that although behaviour can be "explained", it always remains unpredictable.

Table 1.3 Basic assumptions about symbolic interactionism: subjective meaning

Type of assumption	Researcher's assumption	Application in this study
Realistic and nominalist assumptions based on Thomas' theorem	• Human behaviour is unpredictable. • Reality is multiple, subjective and mentally constructed by individuals. • Individuals use different methods to invest meaning in objects, events and experiences. These methods are indicators of the way in which individuals analyse their social world.	• The researcher observed and interviewed the student nurses who participated in this study in the hope of acquiring a deep, accurate and layered understanding of their personal experiences during clinical accompaniment. • The researcher gathered the information (data) she needed by means of involving herself personally in the activities and experiences of the student nurses and their clinical facilitators. The researcher could not have obtained and interpreted this information becoming involved in this way with all the participants who contributed to this study.

(Source: Adapted from Flick 2006:66-67)

Table 1.3 explains how important it was to the researcher to interpret the experiences of all the participants in this study from their own point of view.

1.7.2.2 Epistemological assumptions

According to De Vos (2001:242), the accuracy and success of *quantitative researchers* depend on being able to achieve a total disengagement or epistemological distance from the subjects of their research so that the data that they collect from them will be truly objective. The opposite is, however, true of qualitative researchers. *Qualitative researchers* need to engage with the subjective worldviews and life situations of the participants in a study by means of the kind of intense personal interactions that produce the necessary information that will become the source of the data that constitutes the raw

material for analysis, interpretation and conclusions. The qualitative researcher will thus construct texts or narratives about the world of her or his participants. She or he will then categorise, analyse and interpret all the information contained in these narratives before coming to any conclusions about the meaning and significance embedded in the personal experiences of these participants. This approach to the experience and situations of other individuals is interpretive, "softer", transcendental and anti-positivist in nature (Flick 2006:85).

Table 1.4 Basic assumptions about the construction of social realities

Type of assumption	Researcher's assumption	Application in this study
Since conversational interactions are structurally organised, they cannot be dismissed as disorderly, accidental or irrelevant.	• Decisions that arise out of interactions should be examined cautiously • The research topic is situated in an intense scrutiny of the experiences and conditions of everyday life. • The researcher focuses on how interactions are organised and the emergence of repetitive patterns or themes in the interactions.	• The researcher constructed her own interpretations of the behaviour of the student nurses and tested and clarified her assumptions about their behaviour with probing questions. • The researcher involved the participants themselves in gathering information about the experiences of student nurses during their various phases of clinical accompaniment. • The researcher observed and also interviewed the student nurses in their naturalistic setting, while they were carrying out their normal nursing duties and obligations.

(Source: Adapted from Flick 2006:68-69)

In this study the researcher divided the participants into four groups and members of each of these four groups were asked to provide information and opinions about the experiences of student nurses during their clinical accompaniment. The researcher regarded the social interactions that took place and the information that was gathered by means of these procedures, as "real" in terms of the epistemological assumptions of this research.

1.7.2.3 Methodological assumptions

Methodological assumptions are dialectical and interpretative in nature (De Vos 2001:242). *The South African Concise Oxford Dictionary* (2007:321) defines "dialectic" as the "art of investigating or discussing the truth of opinion; enquiry into metaphysical contradictions and their solutions".

Table 1.5 The cultural framing of social and subjective reality: structuralist models

Type of assumption	Researcher's assumption	Application in this study
Since cultural systems of meaning-attribution somehow frame the perception of observers, they imbue what seems to be a purely subjective reality with the status of social reality (in the eyes of a person who make them).	Deep structures are inherent in all the components and layers of all cultural models, interpretive patterns and all latent structures that are unconscious.	The researcher interpreted the meaning of the student nurses' environments by means of the interactive processes in which she engaged. In this way, the researcher arrived at an understanding of the reality of the working environments of the student nurses *as they experience them*. The relationship of trust that the researcher cultivated with the participants enabled her to facilitate the discovery of a number of immensely important and deep-seated experiences and opinions during the course of the interviews.

(Source: Adapted from Flick 2006:71)

The researcher's ability to listen with total attention during the interviews was conducive to strengthening the relationship of trust that arose between her and the student nurses during the interview. This cultivation of mutual trust and respect enabled her to interpret the responses of the participants from an empathetically subjective point of view.

1.8 DEFINITIONS OF KEY CONCEPTS

After the researcher had undertaken the literature review, she defined the following key concepts that were central to the conduct of this study.

1.8.1 Student nurse

The South African *Concise Oxford Dictionary* (2007:845) defines a **student** as a person who is undergoing active learning or who is studying to enter a particular profession. The word student therefore has many elements in common with the words *apprentice, learner,* a *novice* and refers to a person who is in the process of being educated.

Fitzpatrick and Whall (2005:197) use Neuman's model to describe a **nurse** as an "intervener whose goal is either to reduce the client's involvement with certain stressors or to mitigate his or her perceived suffering through implementation of appropriate interventions". A nurse is a person who tends, comforts and encourages the sick. Ellis and Hartley (2004:150) add that a nurse is a person who nourishes, fosters and protects. The Latin word "nutrire" means *to suckle* and *to nourish*.

According to the *Online Medical Dictionary* (2007:544), *a student nurse* is an individual who is enrolled in a school of nursing for a formal educational programme that leads to a degree in nursing. The *Online Medical Dictionary (2007:544*) describes a student as:

- a person engaged in study, one who is devoted to learning, a learner, a pupil, a scholar; especially, one who attends school, or who seeks knowledge from professional teachers or from books; as in a student from an academy, a college or a university
- one who studies or examines in any manner; attentive and systematic observer; as [in a] student of human nature, or of physical nature

In this study, *a student nurse* is regarded as a person who is undergoing a process of learning how to implement interventions in order to mitigate the complications caused by the injury or illness of patients and who cares to the limits of her or his ability for patients irrespective of class, race or any other discriminatory conditions. The student nurses in this study were pupil enrolled nurses following the SANC's R2175 programme.

1.8.2 Mentorship / mentoring

Muchinsky, Kriek and Schreuder (2003:189) describe mentoring as "a method of facilitating development by older and experienced individuals to learners". This, according to the authors, includes professional "paternalistic" (fathering) behaviour.

Davey (2002:4) supports this definition by adding that *mentorship* is a situation in which "novice nurses are advised and supported emotionally towards promotion of growth and professional competence". Lekhuleni, Van Der Wal and Ehlers (2004:17) describe *mentorship* as "a relationship with nurturing, education and protection".

According to Hunt and Weintraub (2007:35), mentors and mentees participate in an ongoing relationship that is frequently accompanied by a sense of emotional attachment between the two. Mentors may arrange on-the-job learning opportunities by means of tasks and developmental assignments. Mentors also made use of whatever coaching techniques to present themselves (Hunt & Weintraub 2007:72).

For the purpose of this study, the clinical facilitator as a professional nurse is regarded as a mentor who facilitates the tasks of student nurses throughout their training period.

1.8.3 Competence / competency

Competence consists of the knowledge, skills, judgment and personal attributes that are required for being able to perform all the tasks of a competent nurse SANC (2004:58). In the opinion of Zhang, Luk, Arthur and Wong (2001:468-469), *competence* and *competency* are regarded as separate concepts, even though they usually reflect the same meaning. Zhang et al (2001:469) define the concepts of competence and competency as "job-related capabilities for [the] production of expected outputs". Intelligence, motivation, learning skills, general knowledge and personality are all regarded as elements of competence.

For the purpose of this research, *competence* is defined as the skills and experience that a student nurse has gained over two to three years, which enable her or him to set goals and objectives, to devise plans and to formulate strategies in order to achieve that which they want to achieve.

1.8.4 Clinical environment

The word "clinical" is defined by the *Concise Oxford Thesaurus Dictionary* (2002:139) as an adjective that means "objective, uninvolved, neutral or basic". The concept "environment" is used synonymously with the word "atmosphere", and is defined by the *Dictionary of Environment and Ecology* as "surroundings, atmosphere, background, circumstances, conditions and … the surroundings that affect an activity … of any organism, including [those in] the physical world". The *Collins English Dictionary* (2006:523) defines an *environment* as "external conditions or surroundings" and "external surroundings in which a plant or animal lives, which influence its development and behaviour". *Environment* is defined in the Merriam-Webster Online Dictionary (2004:267) as "the circumstances, objects, or conditions by which one is surrounded".

Chan (2004:665) states that *the clinical environment* is the context or setting that surrounds the student nurse while practising or providing nursing care. This concept therefore includes all ranks of personnel, the client and the areas in which nursing care takes place in a health care institution.

An *environment that is conducive to learning* is one of the most important factors that contribute to effective student nurse accompaniment. Chisari (2009:18) recommends the creation of pathways along which an aspirant nurse can walk as she or he learns to master nursing competencies. Such pathways facilitate a new nurse's transition into professional practice. Such pathways will enable student nurses to obtain the knowledge they need to provide proper patient care under the supervision of a preceptor. While a clinical environment that is conducive to the expedition of learning may have the effect of helping student nurses to obtain the necessary professional skills, a troubled and dysfunctional environment will distort and undermine the development and training of genuine

and long-term ethical and nursing skills and competencies (Starr-Glass 2002:512-513; Sleutel 2000:4).

For the purpose of this study, a *clinical environment* refers to the hospital setting in which student nurses are placed for the acquisition of practical nursing skills. In such an environment, student nurses are accompanied by clinical facilitators who are themselves experienced professional nurses.

1.8.5 Experiential learning

Experience, according to Beard and Wilson (2002:13-14), is best defined as "the fact of being consciously a subjective state or condition; of being affected by an event, a state or condition viewed subjectively; and knowledge resulting from actual observation or from what one has undergone". According to Cross and Israelit (2000:26), *learning* is a process that changes the state of knowledge of an individual or organisation. When they have been placed in a clinical setting, students had the opportunity to expand their knowledge and competence by observing the experiences and skills of other students and their preceptors in order to learn by means of discussion (or discourse), conflict, challenge, support and scaffolding from a more competent "other" (Topping 2005:633). This author further asserts that *experiential learning theory* emphasises the primacy of personal experience.

The literature also observes that *direct clinical experience* is required for learning to take place. But raw and first-hand information is not the only mechanism whereby students learn. They also learn from each other – a process that is known as *vicarious learning.* Experience, learning and understanding are inextricably linked (or "mutually constitutive") during the process of participation in practical activities. The interrelationship between these three concepts creates an overlap between the boundaries of thinking and doing. Our experience becomes evident in our speech, knowing and learning (Lave & Wenger 2005:152). Students have to engage in acts of speaking, thinking and doing if they want to be in a position to understand and learn what they need to know and be able to do. Fox (2003:101) is of the opinion that the fact that students learn from observing and imitating one another is a form of cultural learning that

reduces the possibility of intercultural antagonisms. Fowler (2008:428) states that the concept of *experiential learning* indicates that it is a product of *reflection upon experience*. The outcomes of experiential learning are diverse, and they range from the acquisition of new skills through to the kind of personal development that has the effect of raising one's social consciousness.

Malinen (2000:85) defines *experiential learning* as a "process of re-construction [that is] performed by an individual learner". Student nurses are therefore continually placed in a variety of clinical environments and communities so that they will be able to gain experience in the real-life situations in which people live and work.

For the purpose of this study, *experiential learning* refers to the hands-on experiences of student nurses that enable them to obtain the knowledge and skills that they need and to form the values under the guidance that is provided by a clinical facilitator during clinical accompaniment in a hospital context.

1.8.6 Accompaniment

Willison and Kingston (2009:134) define *accompaniment* as a process in which student nurses are supported by a mentor during clinical practice in a clinical environment.

A study that was undertaken at the St Joseph's Healthcare Hamilton Hospital came to the conclusion that the skills and knowledge of nurses working in the mental health field could be developed by means of what the researchers called "cross-training". This process enables students to obtain the knowledge they need by spending most of their time with a qualified mentor (Willison & Kingston 2009:134). This research required students to spend eight months of each year in a hospital while being accompanied by a clinical facilitator (in this study the phrase *clinical facilitator* is used synonymously with the word *mentor*). While clinical facilitators are also regarded as mentors for student nurses during their accompaniment, they are distinguished by the fact that they also perform as learners because they participate in the personal practices and procedures that

are enacted by students as they strive to obtain the professional knowledge that they need (Nehls 1995:204; Diekelmann 1990:301; Koenig & Zorn 2002:396).

Carlson, Kotze and Van Rooyen (2003:33) note that students are subject to feelings of uncertainty and anxiety when they perform in a clinical environment. In this study, Carlson et al (2003) found that there were too few opportunities for the development of competence for student nurses who wish to become proficient in the provision of nursing care. These researchers also observed the unavailability and inaccessibility of clinical staff and their consequent inability to mentor and facilitate student nurses because of time constraints, a shortage or absence of the necessary equipment to perform nursing duties and procedures, a dissonance between the expectations of personnel in the nursing school and in the hospital, a lack of awareness among senior professional nurses about the actual needs and problems of students, and the inability of the clinical staff to provide continuous and meaningful patient-care learning experiences and guidance.

In this study, *accompaniment* refers to the process of student nurse mentorship and support in the hospital in which this study was undertaken.

1.8.7 Nursing practice

Nursing is defined by Merriam-Webster (2004:853) as a profession that accommodates learners and that enables them to be educated in the process of tending to or caring for the sick. Merriam-Webster (2004:853) defines practice as a standardised procedure, a routine, a method or a repeated action that is designed to improve performance. Nursing practice is regarded as an essential component of the nursing curriculum and is an indispensable part of nursing education (Chan 2004:665). All nursing practice takes place in a clinical environment.

For the purpose of this research, *nursing practice* is defined as the imitation and practice of skills, procedures and clinical processes by student nurses in the selected hospital in Gauteng.

1.8.8 Level II hospital

South Africa's National Health Act (South Africa 2003:6) classifies health care establishments; and the Department of Health (2006:10) offers the following preliminary definition of a Level II (regional) hospital as a facility that provides in-patient services as well as specialist and sub-specialist care within the public sector.

In this study, a *Level II hospital* refers to a hospital that offers the services of various specialists in patient care which have been classified and accredited as a training hospital in which student nurses of different categories can be placed for their experiential learning which has to take place under the mentorship and guidance of a clinical facilitator.

1.8.9 Clinical facilitator

The word "clinical" has already been defined in paragraph 1.7.4.

A *facilitator* is one who provides support for individuals or groups in order to achieve change, and *facilitation* is a process of providing support to individuals or groups to achieve beneficial change (Petrova, Dale, Munday, Koistinen, Agareval & Lall 2009:98). These authors also assert that facilitation is intrinsic to the Gold Standards Framework (GSF) of the United Kingdom (UK) that defines palliative care. The GSF informs the standards of a hospital's programmes and procedures. A study undertaken by Petrova et al (2009) revealed that the standards framework was affected by internal and external practice and facilitation factors. This study actually recommended that the standard of facilitation should be raised if the GSF was to be successful.

Harvey, Loftus-Hill, Rycroft, Malone, Tichen, Kitson, McCormak and Seers (2002:577) found that facilitators played a key role in helping individuals and teams to understand what they needed to change and how they needed it to change. These researchers concluded that facilitation should consist of discrete task-focused activities and more holistic processes that would enable individuals, teams and organisations to effect the changes they desired. The website of the

Tabriz Medical University indicates that Haghdoost and Shakibi (2006:311) use the terms “clinical teacher” and “lecturer” synonymously with the term “clinical facilitator”. In addition to this, Haghdoost and Shakibi have emphasised the importance of the role of utilising *lecturers* in clinical teaching rather than in theoretical and purely academic classes. They also concluded that a more comprehensive assessment of lecturer performance could be obtained by taking into account the feedback that emanates from both students and colleagues.

For the purpose of this study, *clinical facilitators* refer to those teachers who were appointed and allocated by colleges to the hospital in which this study took place for the purpose of student support and accompaniment.

1.9 RESEARCH METHODOLOGY

Research methodology refers to the “application of all steps, strategies and procedures for gathering and analysing data in a research investigation in a logical and systematic way” (Burns & Grove 2001:26). *Methodology* refers to the framework of theories and principles on which a research design and method are based (Holloway & Wheeler 2002:287). The selection of an appropriate research methodology or strategy is the key to finding the research design that will facilitate the progress and success of a research project – and it is probably the single most important decision that a researcher has to make. The research methodology must include the research design, the necessary definition and selection of the population of interest, definitions of the variables (the characteristics of the individuals in the population of interest), their status and their relationships to one another, the instruments that will be used for data collection, and the procedures that are contemplated for data analysis (WHO 2001:11).

The methodology that the researcher used in this study is one of qualitative research. The researcher therefore undertook the research project by utilising a systematic, subjective approach. She chose the qualitative approach in order to obtain a deep and sensitive understanding and appreciation of the experiences of student nurses while they were in a condition of clinical accompaniment as well as the opinions of the clinical facilitators of the experiences of the student nurses

as they perceived them in the public hospital in Gauteng province in South Africa. On the basis of the information that the researcher obtained during the interviews that she conducted with all the participants, she made various recommendations that would be useful in the construction of a tool that could improve the efficiency and relevance of the experience of clinical accompaniment on the part of student nurses.

A more detailed and in-depth description of the methodology that the researcher used is provided in chapter 3.

1.9.1 Research design

Research design is defined by Punch (2005:142) as the overall plan for a piece of research that includes four main proposals: the strategy, the conceptual framework, the question of who or what will be studied, and the tools that will be used for collecting and analysing empirical materials. Mouton (2001:55) defines a *research design* as "a plan or blueprint of how one intends to conduct the research". Burns and Grove (2001:223) note that the research design "guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal". The design that the researcher chose guided her in the planning and implementation of the study so that she would be able to achieve the stated aims and objectives (Burns & Grove 2007:553) and ensure the overall integrity of the study (Polit & Beck 2008:764). Once there is an overall plan in place, a researcher will be in a stronger position to control and handle any difficulties that might arise during the research process.

The research design also refers to "the way the researcher guards against, and tries to rule out, alternative interpretations of results". A research design dictates the way in which the researcher will relate the research questions to the data.

In this study, the research design was contextual, descriptive and explorative in nature. A fuller description of the research design is provided in section 3.3 of chapter 3 of this study.

1.9.1.1 Qualitative research

Punch (2005:3) notes that qualitative research is the kind of research in which data is not always reduced to quantifiable or numeric terms (as it needs to be in quantitative research). Welman, Kruger and Mitchell (2005:188) agree with Punch when they point out that qualitative research is fundamentally a *descriptive* form of research. The primary task of a researcher who uses a descriptive research design is to uncover and explicate ways in human beings in particular settings to understand, account for, and take necessary action to manage the problems and difficulties that they encounter (Welman et al 2005:193).

1.9.1.2 Contextual design

A *contextual design* denotes the environment and the circumstances in which the study takes place (Burns & Grove 2005:732; Holloway & Wheeler 2002:34). Babbie and Mouton (2001:272) state that a researcher should aim at describing and understanding all the events that are relevant to a study in the concrete and natural context in which they occur. The context that the researcher used for the purpose of this study was a selected hospital in the Gauteng province of South Africa in which student nurses of various levels were clinically accompanied during their practical training.

1.9.1.3 Explorative design

Welman et al (2005:166) assert that an *explorative qualitative research design* usually makes use of unstructured interviews to formulate questions that will shed light on the most important variables that have been predetermined by the researcher. It is usually impossible to compile a rigid schedule for interviews before the interviews actually take place. In addition to this, the researcher may use in-depth interviews to obtain information about highly sensitive and emotive issues that a participant might be reluctant to describe on paper.

1.9.1.4 Descriptive design

Burns and Grove (2003:200) point out that a *descriptive design* enables a researcher to obtain knowledge and clarity about the phenomenon of interest to the researcher within a particular field of study. A descriptive design is therefore used to develop theories, to identify problems with the current modalities, to justify current practices and the ways in which respondents perform all those actions in which the researcher is interested. Brink et al (2006:102) assert that a descriptive design provides descriptions of variables in terms of which the research questions can best be answered.

1.9.2 Research method

Sarantakos (2005:30) describes *the research method* as the "nature of research design and methods". He further explains that the research method is informed by various assumptions ontological and epistemological assumptions about the nature of reality, and that it also defines what can be regarded as a "fact" in situations where knowledge is being sought. Qualitative researchers accomplish their research aims by talking to participants or by observing their behaviour from an unapologetically subjective point of view, and that they frequently utilise a holistic approach to the collection of data from documents, records, photographs, observations, interviews and case studies. A qualitative research method may involve a small sample of people who are studied in depth rather than a large sample of participants who are studied superficially. In this kind of research method, validity is of the greatest importance because a researcher's investigation must achieve the objective of the study (Welman et al 2009:9).

1.9.2.1 Population and sample

Babbie (2007:190) notes that a "population is a group or collection that a researcher is interested in. It is the theoretically specified aggregation of study elements." A study *population* is the representative aggregation of elements from which the *sample* is eventually selected.

A *sample* represents a small proportion of the total population that the researcher uses to pursue the investigation in a particular setting (Rossouw 2003:108). The same researcher also postulates that the individuals who are selected for a sample should represent the characteristics of the whole population as closely and accurately as possible. Polit and Beck (2006:56) caution that the risk of collecting data from a sample (and not from an entire population) is that it might not adequately reflect the traits and idiosyncrasies of the whole population.

For the purpose of this research, the researcher selected all the pupil enrolled (R2175) nurses who had been placed in the selected hospital for their clinical learning experiences as well as all the clinical facilitators in the hospital who were accompanying the student nurses during their clinical placement in the selected hospital. The sample that the researcher drew for this population consisted of second-year students who had enrolled for the comprehensive four-year course in nursing.

The population, sample and sampling procedures are discussed in greater detail in chapter 3.

1.9.2.2 Sampling techniques

The researcher used a non-probability sampling technique for this study and selected the most representative, characteristic and typical elements as part of the population (De Vos 2001:198-199.) In this study, the researcher identified potentially suitable students when they came into the wards and asked them whether they would be willing to participate in the research project. This procedure represents the essence of purposive sampling techniques. Sampling continues until data saturation has been reached when no more novel ideas are produced by further interviews.

The researcher also implemented the so-called “snowballing technique” to locate some students who were not on the premises at the time when she was assembling the sample because they had either been allocated to other clinics or

the nursing college. This approach is consistent with the procedures suggested by Babbie (2007:184-185).

1.9.2.3 Data collection

Flick (2006:21) notes that the collection and analysis of data can be performed by a whole range of methods in qualitative research. Flick lists the following possible data collection methods:

- semi-structured or narrative-based interviews
- the collection of data from focus groups
- ethnographically based participant observation
- making use of audio visual or video film recordings
- the observation and recording of interactions and the use of visual materials such as photographs and films

The researcher made use of three types of data collection during the various stages of the research. During phase 1 of the research, the researcher conducted three focus group discussions with the student nurses and one focus group discussion with the clinical facilitators who had been allocated to the hospital as methods of collecting data. In this way the researcher managed to elicit the views and opinions of both the student nurses and clinical facilitators about various facets and aspects of clinical accompaniment.

In Phase 2 of the study, the researcher asked the members of the four focus groups for their recommendations about the ways in which the clinical accompaniment of student nurses could be improved from the point of view of both the student nurses and the clinical facilitators in the selected hospital.

In Phase 3 of the research, all four focus groups were invited to explore, describe and identify the expectations that student nurses entertained with regard to their clinical facilitators during the process of clinical accompaniment. These groups were also asked to make recommendations for the development of a tool that could serve as a guide during the clinical accompaniment of student nurses in hospitals.

1.9.2.4 Data analysis

Neuman (2007:328-329) emphasises that a preliminary effort of a qualitative researcher during the data analysis stage should be devoted to the identification and categorisation of recurrent patterns, themes and relationships in the mass of raw data. Because of this requirement, the process of data analysis is relevant during all stages of the research. Neuman (2007:328-329) also asserts that a researcher creates new concepts and theories by observing and creating the relationships that are established between empirical evidence and abstract concepts. He also confirms that qualitative research is less standardised than quantitative research because the information used is couched in the form of words that are diffuse, context-based and might have more than one meaning or implication.

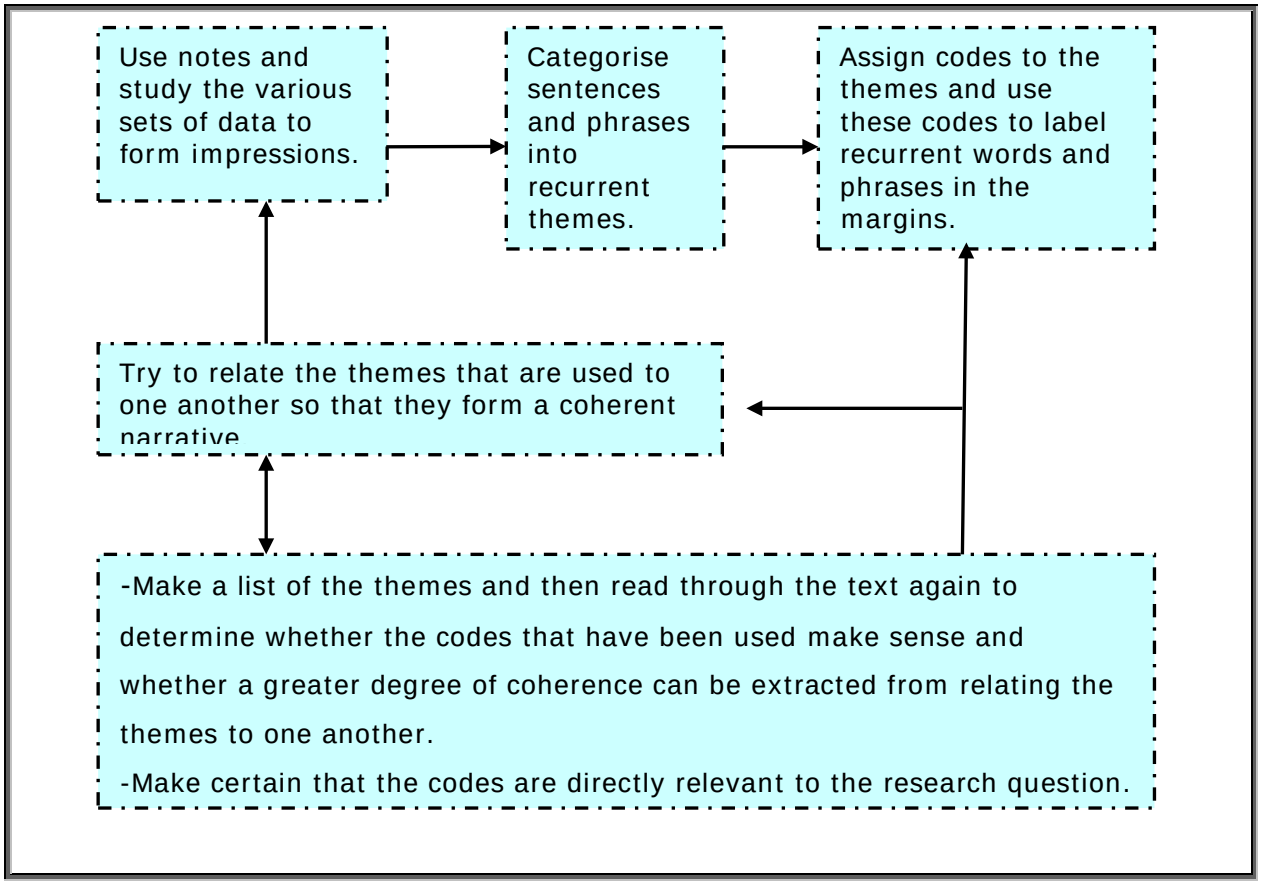

Figure 1.2: The process of coding

(Source: Adapted from Henning, Van Rensburg & Smit 2004:104)

The process of data analysis is fully discussed in chapter 4.

1.10 TRUSTWORTHINESS

Trustworthiness is a measure of the extent to which a researcher's findings reflect the truth about particular situations or entities. All research findings should (as far as is humanly possible) exclude bias and inaccuracies (Polit & Beck 2004:36). In the opinion of Schmidt and Brown (2008:307), trustworthiness refers to the quality, authenticity and truthfulness of the findings in qualitative research. Lincoln and Guba (cited by Schmidt & Brown 2008:307) recommend the following four criteria in order to establish trustworthiness: *credibility, transferability, dependability* and *confirmability*.

- **Credibility**

There are certain procedures that are implemented to achieve the greatest possible agreement of credibility (Babbie 2004:277). In a case of the present study, the researcher used the following procedures: *prolonged engagement, persistent observation, triangulation, referential adequacy* and *member checks*.

- **Transferability**

Once credibility had been achieved, the researcher made sure that she had presented a sufficient amount of descriptive data to allow the application of her findings to larger populations in other contexts and settings that were similar and comparable in context to the conditions described in her study (De Vos 1998:349-350).

- **Dependability**

The researcher also ensured that the findings of her study about the experiences of accompaniment of student nurses could be replicated with similar subjects in comparable circumstances. If this were the case, it would increase the dependability of her research (Babbie 2004:278).

- **Confirmability**

Krefting (1991:219) notes that this criterion depends on the achievement of the truth value and applicability. Bias was eliminated as far as possible from the findings and research procedures by means of decreasing the distance between the researcher and the student nurses. This contemplative distance decreased over the prolonged period of contact she had with her students and as a result of a great deal of self-observation and reflection on the techniques and methods she used in her study. Confirmability is also increased by the neutrality of the data as well as that of the researcher (De Vos 1998:350-351).

The full discussion of these and the other factors involved in trustworthiness is presented in chapter 3 of this study.

1.11 ETHICAL CONSIDERATIONS

Ethical concerns would be implicit in the manipulation of data, the non-reporting of contradictory data and in the deliberate implementation of bias in the interpretation of data by the researcher. Some of the techniques that the researcher used to ensure the integrity of her study were the use of an external auditor, member checking, and the attainment of certainty that the information used in the study was always grounded on verifiable evidence (Munhall 2001:379-380). The implementation of ethical principles during the research process is essential to all research, and is especially concerned with issues of respect, permission and maintenance of confidentiality and the anonymity of the participants throughout the process of study and in all subsequent reports of the study's findings.

Chapter 3 deals with all the ethical considerations of this study.

1.12 THE SIGNIFICANCE OF THE RESEARCH

The significance of this research is that it should create a much greater awareness among professional nurses, nurse educators and lecturers of what student nurses experience during their clinical accompaniment in a particular

public hospital in the Gauteng province of South Africa in which this study took place. An increased awareness of the experiences of clinical accompaniment could be used to improve the techniques utilised when accompanying student nurses during their clinical practice. Such an awareness of the experiences and expectations of student nurses as they are accompanied during clinical practice will give meaningful, clear and educational developmental support to educators so that they will be able to improve the quality of their facilitation of the clinical learning experiences of the student nurses who are entrusted to their care. All these factors should contribute to the significance of the present research.

The research findings in the study could also be used for the following purposes:

- It can serve to heighten the awareness of student nurses to their own reactions to certain situations that inevitably recur during experiences of clinical accompaniment.
- This research should be of interest to clinical tutors, mentors and other professionals in the nursing profession because it will give them a great deal of information about how student nurses perceive the quality of their clinical accompaniment. This in itself should enable clinical facilitators to reflect creatively upon the techniques that they utilise during the processes of clinical accompaniment.
- The results obtained from this study could result in the development of guidelines for clinical facilitators as they engage with their student nurses during the processes of clinical accompaniment.
- The study will be able to increase the understanding of both student nurses (on the one hand) and of clinical facilitators and nurse administrators (on the other hand) as they all participate in the vitally important processes of clinical training.
- This study will provide additional data about the processes of the clinical accompaniment of student nurses. This in itself should lead to improvements and refinements in the strategies that are utilised in the clinical accompaniment of student nurses as they participate in these activities that form a compulsory part of nursing education.

1.13 LAYOUT OF THIS STUDY

The layout of this dissertation consists of chapters and annexure. The layout is depicted in figure 1.3.

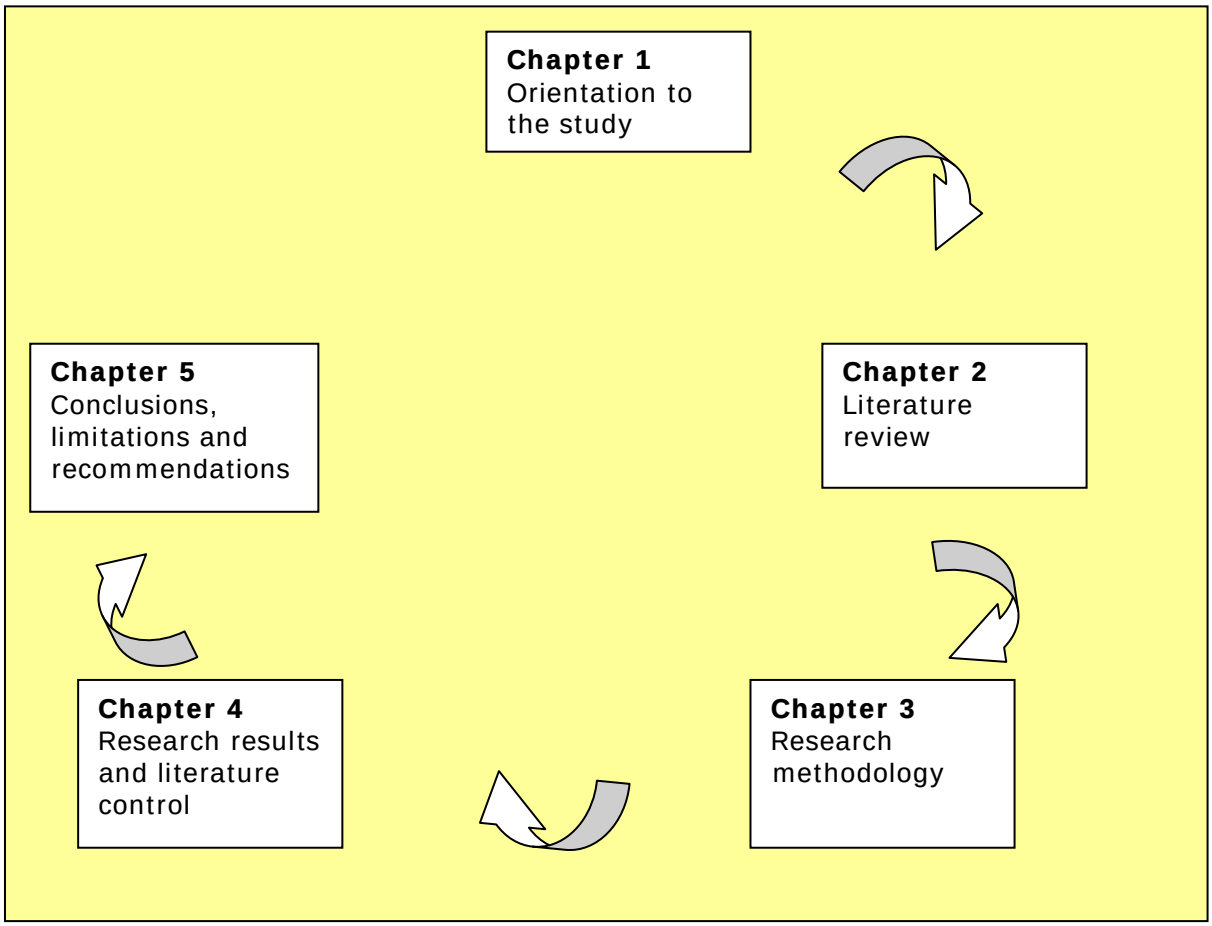

Figure 1.3: The organisation of the chapters of this study

1.14 CONCLUSION

This chapter introduced the study and described the aims and significance of the study. It also provided definitions of the key operational concepts used in this study. Chapter 2 presents an overview of the literature pertaining to the current state of knowledge about the theory and practice of clinical accompaniment of student nurses.

CHAPTER 2

Literature review

"Learning is not attained by chance; it must be sought for with ardour and attended to with diligence."

Abigail Adams

2.1 INTRODUCTION

Chapter 1 provided an orientation to the study. This chapter contains the literature review that provided a theoretical basis for the pursuit of the study. According to Babbie (2007:507), a literature review offers us an understanding of "what's already known and [what] is not known – an extension of what has previously been learned about a particular topic". A literature review therefore relates a study to what has already been discovered about a particular topic, and offers an understanding of the conclusions that have been reached by researchers and scholars in prior studies and discussions about the topic (Creswell 2009:25).

De Vos, Strydom, Fouche and Delport (2006:123) are of the opinion that the purpose of a literature review is to give one a clearer understanding of the nature and meaning of the problem that has been selected for research and discussion. Sarantakos (2005:137-138) is in agreement with this definition, but adds that a literature review places all previous research into perspective by linking it the intended research. She also contains that a literature review locates a study in its historical context and informs a researcher about the theory, methods and techniques that have been used in previous studies and that might be suitable for the present study. In this study, the researcher also made use of the literature review to gain access to sources are identified, discussed and analysed pertaining to the experiences of student nurses during their clinical accompaniment in health care settings. By careful examining and reflecting on

the conclusions and recommendations of previous studies, the researcher was inspired to suggest new ways in which the experiential learning environments of student nurses could be enhanced and improved.

2.2 EXPERIENTIAL LEARNING

Beard and Wilson (2002:1) describe *experiential learning* as "a client-focused, supported approach to individual, group and organisational development, which engages the young or adult learner, using the elements of action, reflection and transfer". These authors further note that experiential learning involves focus on all aspects of both the internal and external environments of an individual, and that it occurs in all walks of life, including play, work and even the most painful and distressing experiences of life.

Innes (2004:45) describes experience as "the interaction of an organism with its environment [an environment] that is [both] human as well as physical". Innes's definition of experience includes all the components of an individual's and a community's personal traditions, institutions and local surroundings. By means of interacting with his or her environment, an individual is able to manipulate the environment to achieve his or her goal, but is also changed and shaped by the environment in the process (Innes 2004:51).

Learning is a process by means of which knowledge is created through the transformation of experience (Cross & Israelit 2000:331). Learning how to learn requires flexibility, adaptability and self-discipline on the part of learners and students. In the context of higher education, a student can only learn by means of self-reflection and personal involvement in the experiences that contribute to new levels of understanding and mastery. Some teachers use what is called "action learning methods" to enable students to learn from their own experience and interactions with the people, events and conditions that will provide the context for their future professional activities. This is especially true of practice-orientated professions such as nursing. Action learning, as a means of experiential learning, has given rise to a number of different approaches.

2.2.1 Uses and meanings of the term "experience"

The researcher has relied heavily on Kolb's understanding and explanations of the core meanings of experience in the adult learning process. According to Malinen (2000:56), Kolb's theory may be compared with the theories of Schön, Knowles, Mezirov and Revan. The main features of this theory include the following assumptions:

- Learning is a product of a continuous process that is grounded in experience.
- Everyone enters learning situations with preconceived ideas about the situation(s) that they are about to encounter.
- People who have any aptitude for learning are able to draw conclusions and learn from their own experience.
- The nature of the relationship of an individual with his or her environment is both subjective and personal, and objective and environmental.

According to Cook, Gilmer and Bess (2003:311), the entire development of a nursing identity can be understood by relating that identity to the experiences to which a nurse has been subjected.

2.2.2 Fundamental features of experience

Malinen (2000:59) asserts that the experiences of each individual adult are made up by what he refers to as a "private mix". Malinen calls this "private mix" of experiences "first-order experiences" which are experiences that have shaped the understanding and identity of the individual by means of *discovery* (Munhall 2001:37). These experiences determine how an adult regards the world and other people and shape what he calls "memory experiences". It is therefore, in his opinion, our *experiences* of life that determine our attitudes to the events of both our inner and outer worlds.

Malinen (2000:59) outlines the following five fundamental properties of experience:

- Every adult has accumulated numerous experiences from the past.
- All these experiences affect the way in which each adult responds to every new situation. Even though an adult might not be able to explain the significance of these experiences rationally, they nevertheless affect all the events that adults encounter in their daily lives. Experience is a feature of the "real life world" of all human beings.
- Because adult experiences are always true to those who experienced them, adults believe in their truth value. In spite of this, it is difficult to define the truth value in status of these experiences in an objective way simply because they *are* subjective.
- Human experiences are always incomplete, inadequate and distorted to a greater or larger extent if one regards them from an objective point of view. This might in fact mean that what human beings think constitutes the truth are in fact misconceptions that, in some circumstances, will result in the construction of fallacious and incorrect theories (Malinen 2000:59).

Munhall (2001:38; 69) notes that experientialists also posit a second group of experiences that they refer to as "second-order experiences". They assert that these experiences are "immediate", and they describe them in terms of the following three main properties:

- They "unlock" part of the adult's first-order experiences.
- They generate holistic disturbances and confusion in adults who had been deeply influenced by negative feelings and experiences over the years.
- They make adults capable of admitting that their ways of seeing things may indeed be incomplete and inadequate.

When adults realise this, they are faced with the options of either defending or modifying their experiences and the assumed continuity of their experiences. This last property (the continuity of experience) applies equally to first-order and second-order experiences.

Stemberg and Zhang (2001:242) make the following observations: "Second order learning styles represent learning orientations that integrate one of the

two dialectics of the learning process, therefore combining the abilities of two basic learning styles." The learning styles described by experientialists were originally denoted by the terms *northerner, easterner, westerner* and *southerner*.

2.2.3 Experiential learning and various theories of action learning

Experiential learning is one of the approaches or theories in which action learning is the central concept (McGill & Brockbank 2004:46-47). Huitt (2009:1) points out that the primary emphasis in humanistic education is focused on the regulation of the affective or emotional faculties of human beings. This internal regulatory system connects a person's experience of the environment with his or her internal thoughts and also creates connections between knowledge, feelings and action. The following three approaches to action learning demonstrate a number of features in common as well as a number of differences.

2.2.3.1 Revan's theory that relies on the use of the assumptions of the scientific method to check the reality status of everyday life

According to McGill and Brockbank (2004:46-47), Revan's theory of scientific method depends on the following three stages:

- The first stage includes understanding the system or context in which the problem that is being addressed is embedded.
- The second stage involves the negotiation and implementation of a solution by using the scientific method and its concomitant features of survey, hypothesis, experiment, audit and review.
- The third stage involves a stage in which a learner uses his or her idiosyncratic ways of understanding the world to check the reality of the phenomena that he or she has experienced.

2.2.3.2 Kolb's theory of experiential learning

According to McGill and Brockbank (2004:47), Kolb's (1984:38), theory of experiential learning originates in a holistic approach to learning that combines

experience, perception, cognition and behaviour in order to make sense of everyday experience. “It is the process whereby knowledge is created through the transformation of experience” (Kolb 1984:38). Kolb has described experiential learning process as a cycle that may begin at any stage but that will follow a sequence of the following four components:

1. concrete experience
2. observation and reflection
3. the formation of abstract concepts
4. the testing of testing new situations

This cycle is illustrated in figure 2.

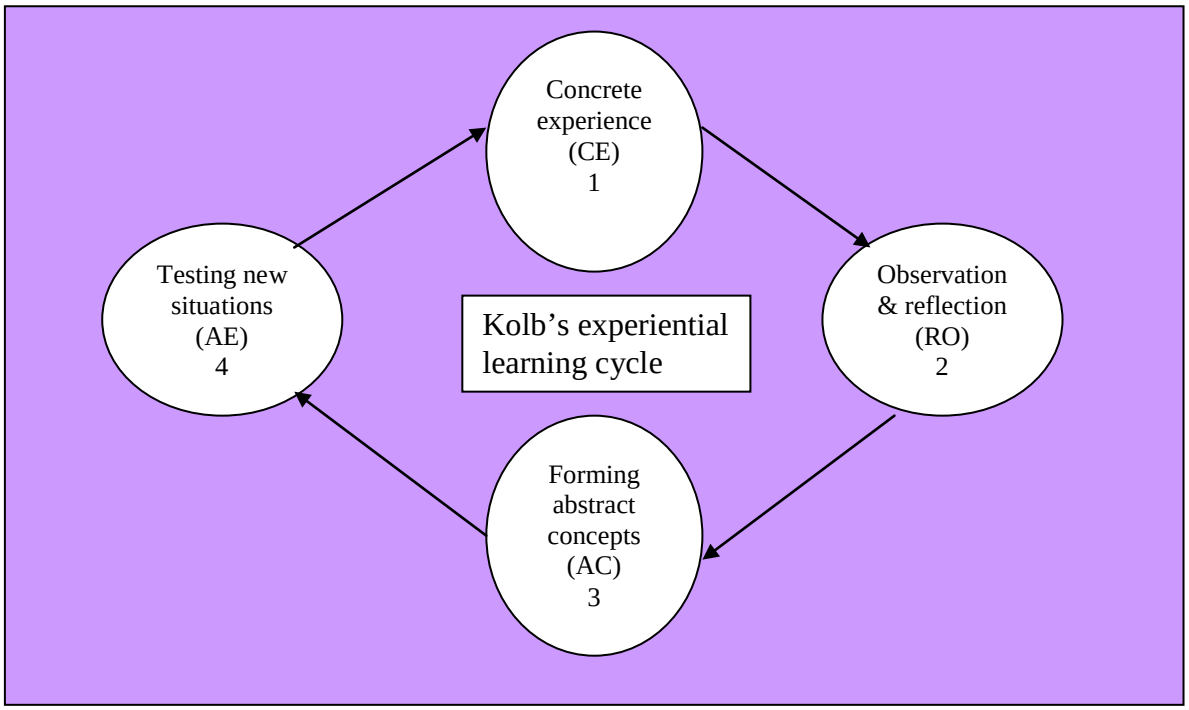

Figure 2.1: A graphic depiction of Kolb’s cycle of experiential learning
(Source: Adapted from Kolb 1984:38)

In figure 2.1, experiential learning is described in terms of the key words that summarise the relevant activity or experience. What follows is a brief description of the four stages of Kolb’s cycle of experiential learning and the key words that describe each stage.

The first stage in Kolb's cycle of experiential learning (the stage of concrete experience) is represented by the word "do". This is the point at which the learner actively experiences an activity such as, for example, a laboratory session or field work.

The second stage in Kolb's cycle of experiential learning (the stage of observation) is represented by the word "observe". This is the point at which a learner is required consciously to reflect on the experience that has just occurred. The second stage may also be the starting point for action that others may either support or challenge. The support or challenge of significant others might result in further action of the same kind or, alternately, the avoidance of repeating such actions or behaviour.

The third stage in Kolb's cycle of experiential learning (the stage of abstract conceptualisation) is represented by the word "think". This is the stage in which a learner will attempt to conceptualise a theory or model that explains what it is that he or she has observed. By engaging in this process of conceptualisation, learners make certain assumptions and this enables them to learn how to respond to similar experiences in the future.

The third stage in Kolb's cycle of experiential learning (the stage of testing new experiences) involves active experimentation or a "plan" by means of which a learner attempts to test a model or theory or plan reactions to future experiences.

All these stages involve recognition of the significance of emotion and social context, and each of them contributes, according to Kolb's theory, to the process of learning (McGill & Brockbank 2004:47; Kolb 1984:38).

2.2.3.3 Mezirow's theory of critical reflection

McGill and Brockbank (2004:47) describe Mezirow's theory of critical reflection in the following way. It is in some ways similar to the theory of experiential learning because it emphasises the need to *reflect* on the assumptions and beliefs that we used to shape our practice and moderate our actions and

reactions to the experiences of everyday life. Mezirow asserted that *critical reflection* can transform a person's point of view because most reactions to the situations that confront us in everyday life are distorted because of our subjective and unexamined assumptions about our life experience. Mezirow (as cited in McGill & Brockbank 2004:47) defines *action learning* as "a first step for participants in a journey toward greater self-insight, greater capacity to learn from experience, and greater awareness".

2.2.4 The characteristics of experiential learning

Malinen (2000:75) is not the opinion that the experiential of adults is actually a process of *relearning*. This process includes a modification of earlier learning by engaging in the following repetitive activities: *re-organisation, re-construction, re-defining, re-thinking, re-shaping, re-interpretation* and *re-formulation.* Malinen also states that the purpose of experiential learning is to "renew a contract with the object", and that this renewal involves various kinds of knowledge, experience, meaning and action. He adds that the "contract" of renewal that is referred to here can be described in terms of adjectives such as *retrospective, critical, analytical, rational, personal* and *internal*.

2.2.4.1 Experiential learning is retrospective

Malinen (2000:76) asserts that when a learner is no longer *in* a situation, he or she has already lived *through* the experience. Any learner must first understand, internalise and master a body of experiences before they will be able to modify similar future and past experiences. He asserts that past experiences are never forgotten but are only stored in a latent form that is subject to recall. A mastery of past experiences can only be obtained in the form of recollection – and cannot be perceived directly. A learner therefore needs to make use of first-order experiences to recall second-order experiences. Andrews, Brodie, Andrews, Hillan, Thomas, Wong and Rixon (2005:1) conducted a study on the clinical placement of students. The researchers found that students were offered opportunities to improve their educational practice in clinically based education. The students' success depended on the quality of their early experiences of socialisation.

2.2.4.2 Experiential learning is critical for the success of practical learning

Malinen (2000:77) considers that the ability to be self-critical is an essential tool for correcting, improving and refining our knowledge. It is only those who are able to be self-reflective and self-critical, are able to correct their mistakes and understand the hidden contradictions and presuppositions that are concealed in their epistemological assumptions. Self-reflection is an essential tool for discovering knowledge that we conceal even from ourselves and for examining such knowledge with the necessary degree of self-scrutiny and honesty. When an ability to be critical of ourselves is combined with an ability to reflect on the past, such reflection is called *transcendental reflection* (Malinen 2000:78; Kant 1996:168). The learner uses the power of transcendental reflection to find solutions to inadequacies and obstacles, and to appreciate that there might be a need to change or modify our attitudes to ourselves and others.

2.2.4.3 Experiential learning is analytical

Malinen (2000:79) also notes that experiential learning is analytical by nature. This characteristic of experiential learning helps us to impose a certain degree of order on the chaotic nature of disorganised experience and on our mistakes and misunderstandings. It is in this way that what is implicit and non-conceptual is changed into explicit and conceptual terms for which accept personal responsibility. The step is known as *explication*, and it builds on what philosophers call *bracketing*. During the process of bracketing, learners are asked temporarily to suspend their previous conclusions and judgments and to focus on them without any interference from the emotions. It also explains the process by means of which human beings have the freedom that enables them to constitute their own world of meaning (Malinen 2000:81).

2.2.4.4 Experiential learning is rational

Malinen (2000:81) also describes experiential learning as rational. He asserts that the ability to be rational is the ability to maintain an attitude of readiness in which we can listen to the critical arguments of others and learn from their

experiences. Although this process reflects the essentially rational component of experiential learning, Malinen agrees that there is another component of experiential learning that is non-rational. This non-rational component of experiential learning requires us to be able to abandon our habitual assumptions and attitudes and to accept new (and possibly disturbing) aspects of experience so that we will be able to cope with this type of experiential learning.

2.2.4.5 Experiential learning is personal

Finally, Malinen (2000:85) asserts that experiential learning is personal. What he means by this is that the meanings that we ascribe to experience are understood, in the last analysis, in terms of our own truth values. Malinen points out that this becomes apparent in the fact that human beings attribute different meanings in value to the same events or phenomena. According to Malinen, all meaning can be described as multi-dimensional and multi-layered, and meanings are constructed from the connections that human beings have made between their own lived experience and their assumptions about value and truth. In conclusion, Malinen (2000:85) emphasises the personal nature of experiential learning in the following words: “Adult experiential learning is [made] rational in terms of personal relevance.”

2.2.5 The various models of experiential learning

The processes of experiential learning are based on the following three models: the model of action research, the model of experiential learning, and the model of learning and cognitive development.

2.2.5.1 The model of action research

According to Cross and Israelit (2000:314-315), this model was first formulated by Lewin and consists of the following two dimensions.

The first dimension consists of the “here-and-now” of concrete experience, which is understood in terms of a cycle that is divided into four stages. The first dimension involves the activities of concrete abstract experience by imbuing

abstract concepts with colour, activity, animation, texture and personal meaning. This initial stage is followed by the collection of data, by observations or reflections about an experience, by analysis of data, by providing feedback and conclusions to the actors involved, and, lastly, by making use of these new experiences.

The second dimension involves making use of feedback. According to Lewin (in Cross & Israelit 2000:314-315), a lack of continuous feedback usually leads to a lack of effectiveness and an inability to sustain goal-directed learning.

2.2.5.2 The model of experiential learning

According to Cross and Israelit (2000:315-316) and Morris (2003:3), this model was first formulated by John Dewey and is similar to Lewin's model - although Dewey also emphasised the developmental nature of learning. Dewey described how learning and be transformed into impulses, feelings and desires that constitute concrete experience and eventually higher-order purposeful action.

2.2.5.3 The model of learning and cognitive development

Cross and Israelit (2000:316-318) argue that this model was formulated by Piaget and suggest that it is similar in many ways to the models of Lewin and Dewey. This model posits that the learning process takes place through a cycle of interactions between an individual and the individual's environment. The development of adult thought materialises through concept, reflection and action. It begins in infancy and matures in adulthood when an adult moves from a concrete phenomenal view of the world to an abstract constructivist view, and from an actively egocentric view to a reflective, internalised mode of knowing. The cognitive development theory devised by Piaget identifies the processes or stages through which an adult has to progress in order to be able to become proficient in effective learning.

2.2.5.4 Learning in working life and the development of competence

According to the comprehensive theory of learning constructed by Illeris (2002a:1), we need to revise our traditional understanding of learning theories order to be able to understand the concept of learning.

Illeris's (2002a:1) theory of learning is based on the following two fundamental assumptions:

> Firstly, learning includes two essentially different types of processes, namely the external process between the learner and his or her social, cultural and material environment and an internal psychological process of acquisition and elaboration in which new ideas are connected with the results of prior learning. Secondly, all learning includes three dimensions, namely, the cognitive dimension of knowledge and skills, the emotional dimension of feelings and motivation, and the social dimension of communication and cooperation – all of which are embedded in a societally situated context (Illeris & Associates 2004:1).

In addition to this, the authors describe four levels of learning that explain what happens when learning does *not* take place.

Figure 2.1 illustrates the process of learning acquisition during a person's working life. Learning acquisition comprises a cognitive component (content) and an emotional component (incentive). Illeris (2002) also identified the following three dimensions in the learning situation:

- Content – This includes knowledge, understanding, skills, abilities, attitudes, etc.
- Incentive – This includes emotion, feelings, motivation and volition.
- Interaction – This includes communication and cooperation.

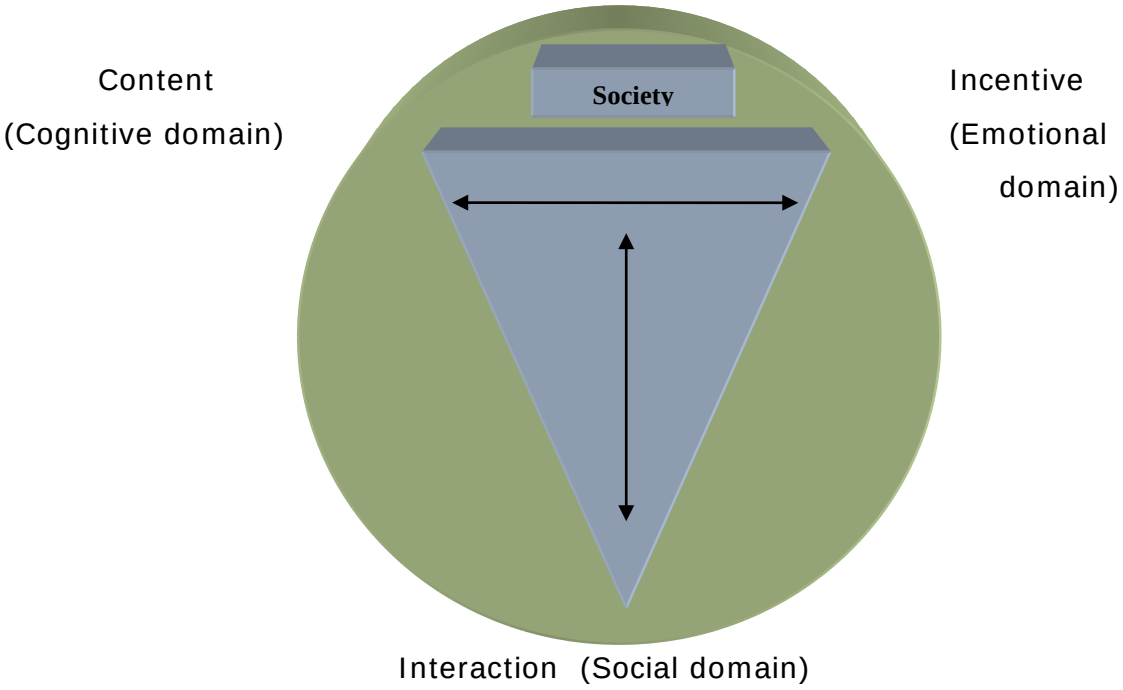

Figure 2.2: Dimensions of the learning situation

(Source: Adapted from Illeris 2002:1)

Figure 2.2 depicts the two basic steps of all learning: the external interactional processes between the learner and the social, cultural or material environment, and an internal psychological process of acquisition and elaboration. These two steps are illustrated by the horisontal and the vertical arrows in figure 2.1 (Illeris 2002a:4; Lave & Wenger 1991:1). According to Illeris (2002), both the external and the internal acquisition processes must be present if learning is to take place.

The individual's learning potentials are located at the top of the vertical axis of the double arrow, while the psychological acquisition process is represented by the horisontal axis of the other double arrow, and is situated at the top of the vertical arrow because it is a process that belongs to the learner. This is a place where the learner is situated. This process illustrates the connections between the function of cognition (which deals with the learning content) and the emotional or psychodynamic function (which provides the necessary mental energy for the process to become meaningful).

The two double arrows – the horisontal and the vertical arrows – form a triangle with three spheres or dimensions that illustrate the claim that learning always involves three dimensions.

According to Illeris (2002:5-6), the cognitive dimension includes the learning content that is necessary for knowledge and skills in which builds up the understanding and the ability of the learner to construct the meaning and ability to deal with the challenges of life and to develop an overall personal functionality. The emotional or psychodynamic dimension encompasses the feelings and motivations of the learner. Its function is to secure the mental balance of the learner and therefore to develop a distinctive personal sensibility. The social dimension is the (third) dimension, and it refers to external interactions such as participation, communication and cooperation.

2.2.6 The characteristics of experiential learning

Cross and Israelit (2000:315-316) point out that all experiential learning is characterised by the following characteristics which are described in the form of statements about learning:

- Learning is best conceived as a process rather than in terms of outcomes.
- Learning is a continuous process that is grounded in experience.
- Learning is a process that requires the resolution of conflicts between dialectically opposed modes of adaptation to the world.
- Learning is a holistic process of adaptation to the world.
- Learning involves transactions between a person and that person's environment.
- Learning is the process of creating knowledge.

2.2.7 Stages of experiential learning

Spouse and Redfern (2000:86) describe experiential learning competencies on the basis of Kolb's theory. These competencies were constructed out of behaviours that were identified in the following five stages of experiential learning:

1. Learning management – In this stage, intentional learning that takes all experiences into account.
2. Concrete experience – In this stage, the individual withdraws from experience and begins to observe it objectively.
3. Reflective observation – In this stage, the individual makes precise observations and creates accurate links between experience and observation.
4. Abstract conceptualisation – In this stage, the individual identifies patterns or regularities in current or past experiences of learning.
5. Active experimentation – In this stage, the individual makes judgments about the experience and/or its effects in relation to the intention to act.

2.3 LEARNING

Cross and Israelit (2000:329) point out that learning can be defined as a process of creating knowledge through the transformation of experience. They add, firstly, that learning follows the process of adaptation; secondly, that knowledge is a transformation process that is continually created and recreated, and, thirdly, that learning transforms experience in both its objective and subjective forms. In order to understand learning, the nature of knowledge and how it is acquired need to be understood.

Sieloff and Frey (2007:167) support this definition of learning by invoking King's conceptual model of learning, in which he describes learning as "a self-activity requiring active participation on the part of the learner". He further asserts that learning is essentially an *individual* processes, and that all learners bring their personal interests, needs, past experiences and different learning styles into their construction of what they learn.

2.3.1 Learning, perception, empathy and self-awareness

Sieloff and Frey (2007:167) explain that if learning is to be effective, perception should be as clear as possible – even though perception is influenced by feelings and emotions. Sieloff and Frey (2007:167) also suggest that the relationship

between perception and empathy forms the basis of learning in nursing. *Empathy* influences learning and our perceptions in turn affect our learning. Self-awareness may be defined as the ability to be aware and conscious of thoughts, feelings, actions, strengths and weaknesses – and the effects that they exert both on ourselves and others. Self-awareness is a skill that needs to be learned from an early age because it is not an invariable feature of human perception. The ability to be self-aware is therefore an invaluable precondition for successful learning.

2.3.2 Levels of learning

Illeris (2002:8) and Illeris (2003:2) describe four levels of learning that are basically constructivist in nature. This means that a learner understands phenomena in terms of mental schemata and patterns that are activated when individuals are confronted by the necessity to learn something new. According to Illeris, learning needs to be located in a structure before what is learned can be retained. The levels of learning that are being referred to are activated by different contexts and conditions. Illeris asserts that all levels of learning can be activated by learners. These include: cumulative learning, which is most important in early childhood; transcendental learning, which is necessary for personality and identity changes, and assimilation and transformative learning, which forms the basis for the kind of general learning with which we most commonly associate the word.

2.3.2.1 Cumulative or mechanical learning

This form of learning usually takes the form of an isolated formation or something that is entirely new to the learner (Illeris 2002:8; Piaget 1972:1).This kind of learning is usually associated with the first year of learning when learners are exposed to entirely new situations and forms of knowledge, and it later occurs in special situations in which the learner is exposed to unfamiliar and unassimilated meanings. It refers to a kind of learning that enables us to recall what we have learned at a later stage and apply what we have learned in similar contexts in the future.

2.3.2.2 Assimilative learning by means of the acquisition of additional facts and skills

According to Illeris (2002:8), this is the most common form of learning. When we engage in this form of learning, we add new elements to what we already know and link these new facts or skills to the existing schemes or patterns that enable us to make sense of our present and past reality. Illeris suggests that an obvious example of this kind of learning occurs in schools in which learners add on what they have already learned in a previous year. On a higher level, assimilative learning takes place over a much longer period of time as human beings develop their cognitive, emotional and social capacities.

2.3.2.3 Accommodative or transcendent learning

Illeris (2002:9) describes accommodative or transcendent learning as a kind of learning that requires us to break down and deconstruct what we already learned in order to accommodate new ideas, situations, attitudes and approaches. An obvious example of this kind of learning occurs when people relinquish long-standing prejudices and replace them by tolerance towards the people or situations that they previously regarded as an acceptable and intolerable. Accommodative or transcendent learning is therefore vitally important for nursing students, religious workers and other health care professionals, whose professions and vocations require them to deal with patients and clients who come from widely differing backgrounds and cultures. But because accommodative or transcendent learning usually requires us to relinquish our prejudices and reconstruct the categories in terms of which we understand reality, it is often a painful experience that requires dedication and a deception of transcendental ethical values such as the tolerance of diversity.

2.3.2.4 Transformative or expansive learning

Transformative or expansive learning is the final form of learning that is considered in this section. It is also an extremely demanding form of learning because it actually requires radical changes to our personalities. It usually involves the simultaneous restructuring over a long period of time (the study

period) of the embedded cognitive, emotional and social dimensions of our personality structure. This kind of learning is an essential precondition for transforming ourselves so that we become purposive and effective members of the professions to which we aspire. Transformative or expansive learning touches us at the deepest levels of our personalities, and recreates us as human beings in all the dimensions of our selves (Illeris 2002:9).

2.3.3 Approaches to learning

In the analysis provided by Streumer (2006:17), learning can be analysed in terms of the following five distinct activities or dimensions:

1. the context in which the learning takes place
2. the individual and organisational contexts of learning
3. the extent of self-direction and self-reliance that learning produces
4. the different forms of learning such as incidental learning, formal learning and informal learning
5. the extent to which a particular individual actually possesses the ability to learn

Streumer (2006:16) and Dunn (2002) point out that neither formal nor informal learning can take place without a kind of reflection that helps learners not to repeat their mistakes.

2.4 REFLECTION

Innes (2004:75) is of the opinion that reflection is an “active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and [any] further considerations [towards which] it tends”. Alligood and Tomey (2006:346) point out that Orlando’s theory of critical thinking was derived from Dewey’s work on reflective thinking. Alligood and Tomey assert that reflective thinking cannot take place unless the following states of mind and activities are firmly in place:

- states of doubt, hesitation, perplexity and the mental difficulty in which thinking originate
- acts of searching, hunting and inquiring to locate the facts or considerations that will resolve the doubts that gave rise to thinking in the first place

2.4.1 Reflection in a caring environment

During the process of caring, reflection is lived out as “reflection-in-action” and as “reflection-on-action” (Alligood and Tomey 2006:115; Watson 1998, 1999, 2005).

2.4.1.1 Reflection-in-action

Alligood and Tomey (2006:115) assert that during the “caring moment”, there is a need to be able to relate to the other with the greatest possible degree of compassion and concern that can be generated by the individual concerned. A nurse seeks to know and understand exactly what it is that has motivated her or him to reach out in a caring way to the patient. It is in such contexts in conditions that the nurse and the patient are able to “find” one another by a mutual process of listening to and appreciating the unique stories, narratives and experiences of the “other”. It only when this takes place at both that nurse and the patient can arrive at deeper levels of meaning, understands and compassionate interaction.

Spouse and Redfern (2000:156) support this hypothesis by reminding us that health care practitioners should be concerned with the humanity of those who are entrusted to their care, and they need to become particularly sensitive to their clients’ narratives about themselves while sharing whatever is appropriate from their own personal experiences of similar conditions.

2.4.1.2 Reflection-on-action

McGill and Brockbank (2004:97) describe reflection-on-action as the act of reflection that occurs *after* an act has already taken place. McGill and Brockbank

argue that this kind of action is indispensable for professional development as well as for effective action learning. Alligood and Tomey (2006:115) also support this analysis of the need for reflection by stating that reflection-on-action generates deeper personal meanings by calm and compassionate reflection on what we have experienced in the past. They also add that reflection-on-action draws on all the physical, mental and spiritual resources of the aspirant student nurse, and it establishes a sound basis for future expertise in those branches of nursing a require caring, empathy, tolerance and understanding.

2.4.1.3 Phases of the reflective process

Klopper (2001:35) describes the following three phases of the reflective process.

The first phase is created by an awareness of uncomfortable feelings and thoughts. In such situations, we perceive that our knowledge and ability to explain what has happened are insufficient for arriving at any truly useful and enduring solution. This phase is usually referred to as “the experience of surprise” while other commentators describe it as “a sense of inner discomfort”.

Klopper’s second phase involves a critical analysis of a particular situation (Klopper 2001:35). This phase is constructive although it includes an analysis and deconstruction of our feelings and knowledge. The following four terms are used to describe critical thinking processes: *association, integration, validation* and *appropriation*. Both, Klopper (2001:35) and Mezirow (1990 analyse these processes in terms of conceptual, psychic and theoretical reflexivity.

Klopper’s (2001:35) third phase refers to the development of a new understanding and appreciation of what we have learned from my experience and reflection.

2.4.2 Criteria for effective reflection

Innes (2004:75) uses Dewey’s model to provide a summary of the criteria in terms of which reflection is described.

Innes asserts that reflection is a meaning-making process that takes a learner from one level of experience to another in such a way that the learner acquires a deeper and more sensitive understanding of phenomena by connecting experiences and ideas in a meaningful way. In this way, the continuity of the learning processes ensured, and learning can be utilised to strengthen the ethical and moral dimensions of society and individual learners.

Reflection is also described by Innes (2004) as a systematic and disciplined method of thinking that he is based on the process of scientific (empirical) enquiry because it takes place in the context of the community as learners interact with others and learn to appreciate the value of personal and intellectual growth of themselves and others.

2.5 CONSTRUCTIVISM

According to Shapiro (2003:125), constructivism is based on the assumption that each individual constructs his or her own perceptual world in a completely unique way. The individual constructs this world and all its concomitant values on the basis of his or her unique experiences, personality and cultural values.

2.5.1 Constructivist theory, teaching and critical thinking

Kincheloe (2005:9) is in agreement with Shapiro about this definition of what constructivism means. He writes: “Different individuals coming from diverse backgrounds will see the world in different ways.” Kincheloe (2005:9) also asserts that the idiosyncratic formations of an individual’s psychosocial dispositions shaped the way in which he or she perceives the world. All such perceptions have important implications for teaching and critical thinking.

2.5.2 Constructivist theory and the learning process

The constructivist theory of learning has been constructed by a number of important and lesser-known theorists and practitioners over the years. In this section, the researcher will briefly allude to the contributions that have been made by the following three theorists and their theories: Vygotsky and his

theory of social development; Bandura and his theory of social learning theory, and Piaget and his theory of cognitive development (Klopper 2001:60).

2.5.2.1 Vygotsky's social development theory

According to Huitt and Hummel (2003:1), Vygotsky's theory is the basis for all later developments in constructivism. His theory is based on the following three major themes and assertions.

The first theme is an assertion that social interaction plays a fundamental role in the process of cognitive development. According to Vygotsky (1980:1), social learning *precedes* development.

The second theme is known as the "more knowledgeable other" (MKO). This term refers to anyone who possesses a better understanding or a higher level of ability than the learner in a particular learning situation in which specific tasks, processes and concepts are being dealt with as. This individual who is more knowledgeable than the learner usually refers to a teacher, a coach, an older adult, a peer; possibly even a younger person or a computer.

The third theme deals with what is called the *zone of proximal development* (ZPD). This refers to the distance or gulf between a student's ability to perform a task under adult guidance (with or without peer collaboration) and a student's ability to solve problems independently and without supervision. It is Vygotsky's belief that the most useful and enduring form of learning occurs in this zone.

Klopper (2001:60) also points out that the ability to learn depends on the knowledge that the student already possesses and the extent to which this knowledge has been internalised and incorporated into the organised cognitive structure of the learner.

Social constructivist theories of learning also state that in order for active learning to take place, the perceptions of an individual about what is real in their world are shaped by their ideas and their ability to put such ideas into practice (Shapiro 2003:349). In addition to this, (Shapiro 2003:353) notes that it is one

of the basic tenets of constructivism that each individual structures his or her own knowledge of the world into unique pattern into which all new facts, experiences and understandings are incorporated so that the learner is able to project and maintain a meaningful relationship with the wider world.

2.6 HOW NURSING STUDENTS LEARN FROM EXPERIENCE IN CLINICAL SETTINGS

Gillespie (2002:570) asserts that humanistic nursing education requires a student-teacher relationship that fosters learning and growth. Learning does not only take place as a result of the activities of trained professional nurses: students also learn from one another in a process that is called vicarious learning (Topping 2005:631). According to Grossman (2007:28), students in nursing are assigned to particular clinical settings and are formally or informally guided by professionals through their experiences over a predetermined period of time that is stipulated by the professional nursing council of the country in which they live. This enables nursing students to become empowered and to develop personally and professionally in a caring, collaborative, culturally competent and respectful environment. It is in such an environment that nursing students learn what they need to know through constructing their own knowledge and drawing their own conclusions from their contacts with the experienced nurses who support and guide them. Such experienced nurses are often called mentors (or preceptors, coaches, assessors, teachers, supervisors, accompanists, facilitators and advisors – all of which are synonyms for the name assigned to those who perform this function).

Grossman (2007:28) argues that there are no universally accepted standards or frameworks for mentoring in nursing. In some cases, the mentor may in fact be someone with less experience or education than the mentee. Table 2.1 provides a comparison of the mentoring roles that were effective during the different eras that they describe.

Table 2.1 Mentoring roles

TERM USED TO DESCRIBE THE MENTORING ROLE	MENTORING UNTIL 1995	MENTORING FROM BETWEEN 1995 AND 2006
Role model	No personal relationship was required to be a role model. What happens in such cases is that the student internalises the behaviours, standards and examples of a role model and adopts them as her or his own (Steward & Krueger 1996).	There was also frequently no personal relationship during this period. Student nurses were confronted by several role models from which they could internalise whatever behaviour and strategies they believed would assist them with their professional and personal growth. *Shadowing* is a term that is used synonymously with role modelling.
Sponsor	Sponsors are often people or organisations who pledge funds. This enables a group can find an appropriate reference group for an individual or a group of individuals (Steward & Krueger 1996).	This term is not used in nursing education.
Preceptor	This term implies the pairing of an experienced employee and a new employee for purpose of orienting a new employee. Pairing is an assigned for a limited amount of time, generally from between two and four weeks (Steward & Krueger 1996).	In terms of this paradigm, an experienced nurse is paired with a less experienced nurse, new graduate, or student (Benner 1984). A certified nurse practitioner with 2 to 4 years experience can act as a preceptor for graduate students who are studying to become nurse practitioners. The preceptor receives credit for the recertification of the practitioner during for precepting.
Peer Strategiser or co-mentor	These terms are applicable to people of similar ages and experience who trade information, guidance and other assistance with the goal of improving one another's situations (Steward & Krueger 1996).	Peer colleagues network in order to assist one another. Each individual in the peer network receives beneficial outcomes from this sharing of information and resources.
Coach	This term applies to the training techniques that are used over a period of an individual's employment by management it and generally occurs on a day-to-day basis (Steward & Krueger 1996).	The process of coaching or helping an individual to use his or her maximum potential has become more respected and is currently viewed as a beneficial process for new employees. It is a commonly used by mentoring nurses, managers and administrators.

TERM USED TO DESCRIBE THE MENTORING ROLE	MENTORING UNTIL 1995	MENTORING FROM BETWEEN 1995 AND 2006
Multiple mentoring	This process permits individuals to network and be mentored by several people simultaneously. One form of mentoring is called vertical mentoring. This involves both mentees and mentors, and each individual performs both roles with a large number of people at any one time. This process began to evolve in the 1990s.	Simultaneous mentoring networks are extremely common in the current world of nursing education, service and academic studies.

(Source: Adapted from Grossman 2007:30)

Table 2.1 emphasises the important benefits that can be derived from the exciting and yet complex phenomenon of mentoring (Morton-Cooper & Palmer 2000:36).

According to West et al (2007:2), the support and guidance of students should ultimately issue in successful practice and learning, and educational bodies should monitor and regulate these practices across the professions in order to reduce ambiguity and confusion when students find themselves working in multidisciplinary and inter-professional contexts.

According to Grossman (2007:2-3), mentoring is a dynamic process of personal and professional development whereby a less skilled person learns from a more experienced person. The less skilled person is usually referred to as a *mentee, student, protégé* or *novice*.

The process of mentoring allows both the mentor and mentee to share their skills and experience. It is the duty of the mentor to remove obstacles, supply emotional support and encouragement, and to offer recognition and praise where it is due.

2.7 TYPES OF MENTORSHIP

In this section, the researcher describes the following types of mentorship:

2.7.1 Multiple mentoring

According to Grossman (2007:9), the most basic and widely understood type of mentorship is that which occurs between two people. Mentoring never involves more than two people at the same time. Reverse mentoring is what happens when a more senior person receives mentoring from a more junior person.

2.7.2 Peers and co-mentorship

Grossman (2007:10) describes this type of interaction as that which occurs between people of equal knowledge, experience and seniority. Whether or not it is effective depends on the ability to generate mutual trust, and, where this happens, both participants benefit equally from the relationship. It is a relationship that is designed to increase motivation and advance the career paths of the participating members.

2.7.3 Role modelling

A mentor (who can also be referred to as a “learning accompanist”) has to be prepared to act as a role model. Such a practitioner congratulates students, encourages them, motivates them, and is exemplary in her or his appearance, oral presentations and writing. She or he is also skilled in the necessary scientific techniques and is able to set standards for practice (Klopper 2000:41).

2.7.4 Coaching

According to Spouse and Redfern (2000:75), a mentor who accompanies mentees in a clinical environment needs to be accountable for four areas of responsibility. These four areas are:

- supervision of the treatment of patients
- the personal tutoring of students in clinical practice
- the continuous assessment of the work and development of individual students

- the availability of support, consultation and supervision in the provision of other means of communication such as telephone-line help

2.8 THE ADVANTAGES AND DISADVANTAGES OF MENTORING

While mentoring is beneficial in the practice of the health care professions, it also reveals certain disadvantages (Grossman 2007:14).

2.8.1 The advantages of mentoring

Grossman (2007:14) notes that the learner, the mentor and their institutions benefit in many different ways from the practice of mentorship. It has been demonstrated, for example, that both the mentor and the mentee are able to learn more quickly. While Cohen, Jacobs, Quintessenza, Chai, Lindberg, Dickey and Ungerleider (2007:164), Setswe (2002:33), and Komaratat and Oumtanee (2009:475) support this notion of the advantages of mentoring, they add that the success of mentorship depends on both parties and is the responsibility of both the mentor and the mentee. Mentors are required, for example, to identify and explicitly teach their mentees those relationship skills and abilities that are necessary for managing one's own life, and for taking care of the lives and responsibilities of others. In this case, mentees are given a variety of opportunities for learning that often result in the creation of life-long relationships and improved one-to-one communication and team spirit in particular work groups. Such advantages and benefits also work in both directions.

Van Rooyen, Laing and Kotze (2005:31), Tsele and Muller (2000:32), and Gagliardi, Perrier, Webster, Leslie, Bell, Levinson, Rotstein, Tourangeau, Morrison, Silver and Straus (2009:55) point out that the accompaniment of student nurses by nurse educators in clinical settings strengthen the relationships between professional nurses, patients, colleagues and other members of the profession by enhancing corporate and professional values and by increasing the loyalty and productivity of student nurses while decreasing the turnover (redundancy) rate of new recruits.

2.8.2 The disadvantages of mentoring

According to Carlson et al (2003:30) and Uys and Meyer (2005:11), the study that was carried out on the accompaniment and mentoring of students revealed that:

> students experienced the nature of the clinical learning program as disrupting in patient care learning experiences, and the guidance and support by the nursing personnel in the clinical learning environment as inadequate (Carlson et al 2003:30; Uys & Meyer 2005:11).

The study also revealed the extent to which professional and experienced staff members are unavailable and inaccessible for the purposes of mentoring because of time constraints and a lack of awareness on the part of ward staff about the real needs and problems of student nurses in the clinical health care environment. Andrews and Wallis (1999:201) and Straus, Chatur and Taylor (2009:135) also point out that there is a great deal of confusion about the concept of mentorship and the actual role of the mentor. They also noted that several participants in their study stated that they had experienced great difficulty in finding suitable mentors and in establishing productive relationships with those they did find.

In addition to the findings of these researchers, Grossman (2007:15) listed the following disadvantages of mentorship during the professional accompaniment of student nurses in clinical settings:

1. Some mentors reported that clinical accompanists manipulated their mentees.
2. Some mentees reported that they were treated without any degree of dignity by their mentors.
3. Some mentees reported the existence of personality incompatibilities between themselves and their mentors, and reported that they were disturbed by the “power-mongering” attitudes of mentors.

4. A number of students stated that some of their mentors were actually resentful and jealous of their mentees and that they actively sabotaged their careers.
5. Students reported that some mentors would not return student calls for consultation or would be actively hostile during telephone calls.
6. Some student nurses reported cases of physical and psychological abuse, possessiveness, jealousy, credit-taking and deceit.

All of these were issues that were listed by Grossman (2007) as being typical of the experiences of many student nurses. Such activities and attitudes obviously diminish the potential advantages of the mentoring paradigm.

2.9 THE APPLICATION OF EFFECTIVE GUIDELINES FOR CLINICAL ACCOMPANIMENT IN HEALTH CARE SETTINGS

Table 2.2 Guidelines for clinical accompaniment of students

The five dimensions of the clinical accompaniment of students	Fifteen guidelines for effective accompaniment
Accompaniment needs	Perceive each student as a unique individual. Create a positive attitude in students towards learning. Use reflective teaching strategies and make use of an in-service training programme.
Involvement in curriculum planning	Ensure that students (and especially field staff) are involved in curriculum planning. Ensure the standardization of procedures. Ensure the application of the theory that has been learned. Ensure the process of two-way communication between students and instructors. Approach each student holistically (in terms of their physical, mental and social development). Ensure the explicit formulation of defined objectives.
Learning environment	Create a safe environment that is conducive to clinical learning. Make sure that students are properly orientated to the clinical situation.
Supervision of students	Facilitate performance appraisals. Serve as a role model and mentor. Provide continuous supervision.
Evaluation	Conduct formative and summative evaluations.

(Source: Adapted from Motlhale 1999:2)

2.9.1 Accompaniment needs

According to Huitt and Hummel (2003:1), Piaget described how an organism adapts itself to its environment. He described disability to adapt to an environment as *intelligence*. According to Piaget, a human being adapts to its environment are making use of mental schemes. This theory further explains that during adaptation, an organism makes use of the processes of assimilation and accommodation. *Assimilation* includes the transformation of an environment while *accommodation* involves changing the cognitive structures that are used to incorporate new information from the environment.

During the process of accompaniment, students need to make use of both assimilation (to change their practical environment) and accommodation (that enables them to assimilate all their training experiences and knowledge and to acquire the skills that are taught by their peers, colleagues, other staff members and the clinical teachers that they encounter in the wards).

2.9.2 Involvement in curriculum planning

Huitt and Hummel (2003:3) and Rogers and Freiberg (1994:3) describe the characteristics of a kind of facilitative teacher that is needed by students in the following way:

- A facilitative teacher tailors the content of an individual student's frame of reference. This means that the clinical facilitator should create explanations that are appropriate to the immediate needs of learners. This can be done in consultation with all other staff members who participate in clinical teaching.

- A facilitative teacher makes use of student ideas ongoing instructional interactions. This implies that the teacher will involve the student and make use of some of the students' ideas during facilitation.

- A facilitative teacher will carry on discussions with students by means of *dialogue*. This means that a clinical facilitator will engage students in debates about patient care in order to facilitate learning.

- A facilitative teacher will be eager to find opportunities to praise her or his students. A facilitator praises students whenever they do well so that her or his students will be motivated to reach the same standard of excellence in the future.

- A facilitative teacher will attempt to create a friendly environment for her or his students. By doing this, she or he will be able to maintain a relaxed environment that is conducive to the acquisition o isf learning.

- A facilitative teacher is responsive to the feelings of students. This requires the teacher to observe how her or his students react during clinical exposure. During such exposure, a good facilitative will intervene according to a student's needs. During this process, a clinical facilitator will have many opportunities to engage each student as a unique individual and will be determined to deal with each student holistically, as complete physical, mental and social beings.

- A facilitative teacher is described by Huitt (2009:2) and Gage and Berliner (1991:2) as one who adopts a humanistic approach for the development of the following objectives:

    - Students will learn best what they want and need to know. Students develop their needs on the basis of the way in which they analyse their skills so that they will be able to direct their behaviour and so learn more easily and quickly.
    - Knowing how to learn is more important than acquiring a lot of knowledge. During clinical accompaniment, students also learn how to learn without acquiring too much unnecessary information. This is the reason why it is so important to have a planned curriculum for all levels of training.

- Self-evaluation is the only really meaningful and effective form of evaluation of a student's work. The emphasis here is on the student's "internal development and self-regulation". Students learn to direct their learning on their own – mainly through learning from others and from trial and error.
- Feelings are as important as facts. It is important continuously to observe the feelings of students' during any kind of teaching so that the nursing instructor will be in a position to ensure that her or his students have understood what is being taught.
- Students learn best in a non-threatening environment. According to the author, the humanistic educators have made an impact in education due to this aspect. In order to produce highly motivated older students, these theorists believe that the environment must be cool and neutral psychologically, emotionally and physically.

The purpose of nursing education is specifically directed at the development of the student nurse as an adult who needs to operate on a personal and professional level. The cognitive, affective and psychomotor development of a student nurse should be completed by the learning process (SANC 1992:5). The development of analytical, critical-evaluative and creative thinking skills are therefore of the utmost importance. Creative thinking skills will enable a student nurse ultimately to become a competent professional nurse who can make independent clinical judgments in order to provide optimal nursing care to patients – care that is safe and within their scope of practice (SANC 1992:5). Student nurses should therefore be assisted to integrate theory and practice and, if any deficiencies in their training are identified, efforts should be made to eliminate them (Kelly 2009:886).

Quinn and Hughes (2009:341) indicate that the learning that occurs in a real clinical setting is more meaningful than that which is acquired in the classroom setting. This belief has been strongly emphasised by Rolfe (1996:26), who asserts that theory is implicit in clinical practice. A great deal of cooperation is therefore required among nurse educators, clinical facilitators, preceptors and the professional nurses who work in the units or wards where students are

placed with the ultimate aim of ensuring that students will be provided with maximum clinical exposure (Jerlock et al 2003:219).

2.9.3 The correlation of theory and practice

Since the profession of nursing is both a science and an art, the training of nurses relies on both theory and on the clinical application of knowledge in real clinical settings. Clinical accompaniment in such settings helps student nurses to integrate their theory and practice and to achieve their envisaged learning outcomes (Bezuidenhout 2003:19). Nurse educators are often challenged on the grounds of the numerous roles and functions which they have to perform. These include administration, the facilitation of learning (which includes both teaching and clinical support), and the necessity to conduct and publish research.

Nurse educators are required to help their students to make the necessary connections between theory and clinical practice – and vice versa. According to Gillespie and McFetridge (2006:631), student nurses should not be left alone to make their own connections between theory and clinical practice. McCarthy and Murphy 2008:303) support this assertion and add that the requirement of making connections between theory and clinical practice is immensely demanding because it compels nurse educators to keep abreast with the latest developments in clinical practice throughout the world to ensure that the support that they give their students is grounded in both theory and clinical practice.

2.9.4 Clinical supervision

Cele, Gumede and Kubheka (2002:42-43) investigated the functions and roles of clinical preceptors. The researchers came to the conclusion that 87.5% of the professional nursing supervisors, who worked in wards and also participated in their own studies, were unable to supervise students. This was attributed to their heavy workloads that prevented them from being actively involved in the clinical teaching and instruction of student nurses (Cele et al 2002:47). The expectation of the SANC (SANC 2005, [SA]) is that nurse educators should spend *at least* 30 minutes per fortnight per student in the clinical

accompaniment of students in clinical settings if they hope to ensure the proper integration of theory and clinical practice for their student nurses.

In research conducted by Waterson, Harms, Qupe, Maritz, Manning, Makobe and Chabeli (2006:70) into the strategies that are currently being used to improve the performance of students in nursing colleges, it was revealed that nurse educators could not cope with the increasing number of students because of the merging of nursing colleges. It is therefore assumed that nurse educators have a very limited amount of time to spare for the clinical accompaniment of student nurses. These were also the findings of a study that was undertaken by Lekhuleni et al (2004:23) into perceptions about the clinical accompaniment of student nurses in the Limpopo Province of South Africa. In this study, the participating student nurses indicated that their nurse educators were frequently not available when they were needed to clarify specific aspects of theory and practice. Bezuidenhout (2005:19), Davhana-Maselesele (2000:126) and Mabuda, Potgieter and Alberts (2008:23) and also reached the conclusion that the supervision of student nurses by professional nurses and nurse educators in clinical settings are currently ensuring that the students will be able to make the necessary connections between the theoretical and clinical components of nursing science.

2.9.5 Evaluation

Quinn and Hughes (2007:265) state that one of the roles of clinical facilitators is to evaluate theory and clinical practice. These researchers came to the conclusion that student nurses regard evaluation as the most important aspect of their learning and the main priority of their tasks because they reflect the extent of their own competencies as well as their shortcomings. Mellish and Wannenburg (1992:131) are of the opinion that the outcome of evaluation may take the form of a symbol or a mark. The symbol that is obtained during formative evaluation will provide a basis for feedback and for progress in meeting the objectives of the programme. It should also provide a basis for evaluating the development of competencies in practice. Summative evaluation, on the other hand, can serve as the tool for allowing students to be promoted to

the next level of their studies or for what they still need to do to complete their programmes. This type of evaluation is final in nature (Oermann & Gaberson, 2006:4-5), and is conducted in a nursing college.

Mellish and Wannenburg (1992:131) assert that evaluation is expected to be undertaken by all those who are involved in the education and training of students. Competence and expertise in related field provide the criteria for the kind of evaluation that is needed to make proper judgments. This factor is often ignored in nursing education. This is one of the realities of nursing education because a nursing instructor's competence to perform an evaluation is seldom tested.

2.10 CONCLUSION

Chapter 2 provided the literature review on which this study is based, and its main focus was on experiential learning, learning, reflection, and the clinical accompaniment of student nurses. Chapter 3 deals with the research methodology that the researcher used in this study.

CHAPTER 3

Research methodology

"Learning is not attained by chance; it must be sought for with ardour and attended to with diligence."

Abigail Adams

3.1 INTRODUCTION

Chapter 3 describes the research methodology. In chapter 1, the researcher described the research problem, the formulation of the research questions and the objectives of the study. This chapter describes the research design and research method that the researcher utilised in order to accomplish the aims of this study.

Research methodology is the application of all the steps, strategies and procedures that a researcher uses for gathering and analysing the raw data that emerges from an investigation in a logical and systematic way (Burns & Grove 2001:26). The selection of an appropriate research methodology or strategy is central to the research design, and is probably the single most important decision that any researcher has to make. The research methodology of this study was guided by the objectives of the study which were set out in chapter 1.

3.1.1 Aim of the study

The most important aim of this study was to identify, describe and discuss the experiences of a sample of student nurses during their periods of clinical accompaniment in a particular public hospital in the Gauteng province of South Africa by means of a qualitative research design.

Welman, Kruger and Mitchell (2005:8) describe the aim of qualitative research as an effort to describe how individuals construct the social, professional and personal reality in which they find themselves. Qualitative research of this kind

emphasises the relationship between the researcher and the object of a researcher's study, and it also emphasises the value-laden nature of the enquiry.

It is a feature of qualitative research that it relies on establishing a coherent and thematic analysis of the various processes and meanings that are discernible in the data. Qualitative research does not analyse research problems in terms of quantifiable and numeric units, quantities, amounts, intensities and frequencies. It approaches its research problems in terms of an analysis of the themes and meanings that emerge from the subjective data that the researcher obtains from the participating respondents in interviews or by means of other research instruments such as questionnaires or surveys.

3.1.2 Research questions and objectives

Munhall (2001:67-68) states that research questions in qualitative research should be holistic in their approach. This means that the researcher should study the human experience and realities that are part of the lives of the participants, and that the research respondents should, as far as possible, be studied in their natural professional, social or domestic environment – or whatever environment is relevant to the research question. Brink, Van Der Wal and Van Rensburg (2006:80) state that some researchers refer to questions and objectives as "questions" while other researchers regard "research questions" as being synonymous with "research problems". It is obvious; however, that the final form of the research questions will be based on a careful analysis of the research problems that the researcher has identified. Hill and Howlett (2005:101) describe "objective information" as data that can be verified. The objectivity and reliability of qualitative research depends on the coherence of the arguments and analyses that are performed by the researcher as he or she attempts to arrive at a plausible solution to the research question.

3.1.2.1 The context of the study

De Vos (2001:281) explains the idea of "context" as the "study of people in their habitat or natural setting [which the researcher investigates] in order to understand the dynamics of human meanings as full as possible".

This study was carried out in of a regional public hospital situated in the Gauteng province of the Republic of South Africa. This hospital is described as a Level II regional hospital in terms of the Southern African government's classification of hospitals. It is also been designated as a multi-disciplinary hospital that is authorised to offer clinical accompaniment to student nurses who are being trained in government-sponsored nursing training colleges, in the South African Defence Force Military College and one other approved private nursing school (college). The hospital in which the study took place has 311 beds. It also has seven ICU beds (2 of which are inactive). Other facilities at the hospital include four 30-bed medical wards, two surgical wards, one paediatric ward, a 30-bed neonatal high care unit, one maternity ward, various operating theatres, a casualty department, some polyclinic departments and various other facilities that are common to large hospitals such as a pharmaceutical dispensary, laundries and kitchens.

Student nurses are allocated to all the wards of the hospital in terms of the requirements of the various curricula that are sanctioned by the SANC and the study years in which student nurses find themselves. The periods during which student nurses have to present themselves for clinical accompaniment in this hospital are stipulated by the requirements of the SANC. Each qualifying nursing college sends its allocation lists to the nursing management department for incorporation into the macro-allocation schedule of the hospital. This process of allocation enables the nursing management and administration department to control the nurse-patient-student ratios in each of the wards and to determine the quality of exposure that they expect each student to receive. Each college employs a clinical tutor who accompanies students clinically and who takes ultimate responsibility for managing the allocation of students and the training that they will receive in terms of the SANC regulations.

The average length of stay (ALOS) for patients in this hospital ranges from between six hours (in the maternity ward) and 30 days in other wards, while the bed-occupancy rate is consistently above 90% throughout the hospital because of the enormous demands that the communities in the hospital's population catchment area make on the services that have been provided by the hospital to all sectors of the population since 1994.

The patients who are admitted to the hospital include patients of all ages, races and gender groups and the health problems, conditions, diseases and injuries with which they present vary in complexity and prognosis. All patients are triaged on the basis of the acuity level of their illnesses, conditions or injuries, after which they are admitted to different wards or are transferred to other hospitals which can offer more advanced health care services. The classification is done in terms of which patients are categorised into priority one (P1) patients and priority two (P2) patients. Priority three (P3) patients are dealt with in the emergency unit where they are treated before being referred to primary health care services for follow-up or further treatments.

3.2 RESEARCH DESIGN

Green and Thorogood (2004:34) assert that a research design refers to "the what, how and why of data production" and that the research question will, to a large extent, determine the most appropriate research design for a particular study. The researcher adopted a qualitative, explorative, descriptive, and contextual research design because she considered it to be the most appropriate design for answering the research questions that were outlined in chapter 1 and for attaining the stated research objectives.

3.2.1 Qualitative aspects of research design

Welman et al (2005:193) point out that qualitative research is most useful for studying and analysing the lives, stories, narrative, attitudes, rituals, behaviour, the way in which groups are defined and organised, and the social interactions and relationships that occur within a predetermined group (who constitute the *sample* of the research). Qualitative research is also used to identify and understand the reality that lies behind (that explains) what might be otherwise mysterious or impenetrable phenomena. It is this kind of research that enables the researcher to acquire an insider's understanding of events and phenomena that those within the sample may understand, but which are opaque to those who are not part of the group.

The data that is generated by the research techniques of qualitative research and recorded in written or coded form (Avis 2005:5; Bowling 2007:352). Because the participants in the research are encouraged to express their views and opinions in their own words and in their own terms (Avis 2005:5), a qualitative researcher needs to interact with the participants in order to obtain the raw data that will later be refined in order to produce coherent explanations and meanings. These interactions with members of the research sample are collectively referred to as *fieldwork* in qualitative research. Polit and Beck (2006:500) define *fieldwork* as "activities undertaken by researchers to collect data out in the field". (The word field may be understood in either a little or metaphorical way in this context.) The data for this study was collected from the observations and the responses that the researcher collected from the sample during focused group discussions (see chapter 4 for a more detailed discussion of this aspect of the study).

The researcher is the prime agent of research and becomes the instrument or agent through which the data is accumulated. It is for this reason that the researcher has to be entirely competent and familiar with every aspect of the entire research process (Henning et al 2004:10). Complete objectivity is impossible in qualitative research because it is the researcher herself or himself that performs the analysis of the data (Streubert Speziale & Carpenter 2007:12). But "complete objectivity" is not what is being sought in qualitative research. It is the aim of qualitative research to produce logically coherent and meaningful explanations for the repetitive themes and patterns that are contained in the data that she or he collects.

A qualitative survey usually involves a limited (small) sample of respondents. Deliberate (non-random) and purposive techniques are used for selecting a suitable sample. The criteria for selection focus on various subjective and rationally selected characteristics (such as *poor, old, students, girls, nurses*) of the whole population from which the sample will be drawn (Bulmer & Warwick 2000:135).

The researcher used open-ended questions as technique for eliciting responses from the participants. The researcher combined this method with other non-

formal, flexible and unstructured methods in order to maximise the cooperation and willingness of the participants to impart with their views – even though these might be interpreted as reflecting the researcher's prejudices and views (Bulmer & Warwick 2000:135). The problem of bias and subjectivity in qualitative research will be dealt with later in this study.

Qualitative reasoning is inductive in nature. This means that the researcher first formulated specific assumptions about the problem (these were stated in chapter 1) before she began to make observations. These observations were combined with questions, the answers to which included the opinions of the students about various issues. Once the researcher had gathered all the data, she formulated a theory to explain what she had heard and observed (Du Plooy 2002:83).

3.2.2 Explorative part of the design

According to Bless and Higson–Smith (2000:41) and Welman et al (2005:201), exploratory research is most useful for obtaining a broad but accurate understanding of a particular situation, phenomenon, community or group of people. The need for this study arose out of a lack of accurate information about a particular area of interest (the experiences of student nurses during the process of clinical accompaniment). There are no great differences between exploratory and descriptive research. Both depend on case studies and surveys of attitudes, opinions and conditions. Bless and Higson–Smith (1997:41) and Welman et al (2005:201) also point out that exploratory research helps a researcher to clarify problematic concepts and enables her or him to compile a list of possible answers and solutions to predefined questions.

The qualitative researcher therefore asks research questions that will generate the necessary data that will ultimately provide an understanding of the specific phenomenon in which she or he is interested (Green & Thorogood 2006:6). This is what the researcher had to do in this study because the main problem that she had set herself was to identify, describe and understand the experiences and difficulties faced by student nurses during their periods of clinical accompaniment in the hospital setting. The researcher therefore interviewed

each focus group until she felt that the saturation had been reached. This point is identifiable because the participants begin to repeat the same information in answer to different questions, and then there is no point in continuing with questioning because no new inputs are received (Polit, Beck & Hungler 2001:470).

It was inevitable that this study would be explorative in nature for the researcher to be able to obtain an understanding of phenomena about which, as yet, very little is known (Babbie 2004:89). And so the researcher engaged in this exploratory study in order to:

1. satisfy her own curiosity about these phenomena
2. to obtain a better understanding of these phenomena
3. to acquire the information that would be needed in order to design and construct a nursing record-keeping tool that could be useful to the profession
4. to be in a position to monitor and reflect on whatever further actions might be implemented in the future

This researcher enhanced the explorative design of the research process by engaging in an intensive literature review about the issues that the research topic raises so that she would be in a position to verify or contradict her own research findings in the ultimate stage of the research. This implied that the researcher was willing to accept new ideas and possibilities and that she would not close her mind to other possible explanations of the same data and the findings of other research about the phenomena in which she was interested. The researcher therefore made use of bracketing which Burns and Grove (2007:532) describe as a “qualitative research technique of suspending or laying aside what is known about an experience being studied”, in an attempt to set aside and suspend her own preconceptions so that the data could be examined with a refreshed and unbiased attitude (Todres & Holloway 2006:229).

The researcher also explored the dimensions of the research problem by means of observing the actions, attitudes and behaviour of the students and their

clinical facilitators during the clinical accompaniment process, and by conducting an intensive literature review.

3.2.3 Descriptive aspect of the design

When in combination with an explorative approach, a descriptive research method is an extremely valuable tool for increasing one's understanding of the questions raised by the people, situation or events that the researcher is striving to comprehend (Welman et al 2005:23). These authors note that a descriptive research seeks to explain phenomena and also to predict future behaviour in comparable circumstances. The researcher observed nursing students in their work setting while they were engaged in clinical accompaniment, and after she had done that, she proceeded to describe what she had observed. The process of data analysis commenced during the data collection stage. At first the researcher analysed the data manually in order to organise, provide structure and elicit repetitive meanings and themes from the mass of inchoate data (Polit et al 2004:381). She then transcribed the data verbatim from tape recordings and field notes (Andrew & Halcomb 2009:188) so she would position to verify the data and immerse herself in the transactions that had taken place between her and the interviewees.

The researcher used a descriptive design to:

- observe experience of student nurses in situations of clinical accompaniment and to describe new or additional knowledge about these experiences that had not hitherto been described by researchers
- to describe how certain guidelines could be used for the clinical accompaniment of student nurses by accompanists and professional nurses

3.2.4 Contextual features of the research design

The researcher's main objective in studying the student nurses in their clinical accompaniment context was to enable her to "study people in their habitat or natural setting in order to understand the dynamics of human meanings as fully

as possible" (De Vos 2001:281). While qualitative research is usually performed on a small scale (it is also called "micro research"), it always strives to be faithful to its holistic design. It attempts to offer a detailed description and analysis of participant observation. The contextual aspect of the research design was used by the researcher to identify student nurse experiences in the actual environment in which they worked while they were being clinically accompanied.

In this study, the researcher first observed the student nurses at work without any preconceptions, and then reported the evidence that she had collected before she expressed her own opinions about what she had seen.

3.3 THE RESEARCH METHOD AND PROCESS

Burns and Grove (2003:374) argue that a qualitative research design includes the selection of participants, a period of data collection, a phase of data management and, finally, a careful and thematic analysis of the data that had been collected.

The researcher abided by all these requirements as she made various choices and took purposive action to answer the research questions that she had formulated (De Vos et al 2006:272; Newell & Burnard 2006:22). Newell and Burnard (2006:22) point out that the research method has to be "practicable" and that it has to fall "within the expertise of the researcher". Since a qualitative research methodology allows a certain degree of flexibility, it evolved as the researcher investigated the depth, richness and complexity that was inherent in the identification of the components. In order to be able to answer the research questions, the researcher first identified the *population*.

The study consisted of the following three phases:

- Phase 1: The explorative phase
- Phase 2: The evaluation phase
- Phase 3: The recommendations

Each phase and its realisation in this study are described in depth.

Phase 1: The explorative phase

Phase 1 consisted of two steps (see table 1.2). Each step is discussed with reference to the research question; the research objective, the population and sampling, the data collection techniques, the data analysis and the steps taken to ensure trustworthiness (see sections 2.5.1 to 2.5.3).

3.3.1 Step 1

The research question that informed step 1 of phase 1 was: “What are the views of student nurses about their experiences during clinical accompaniment in the selected hospital?”

The objective for step 1 of phase 1 was: “How best can one describe the views and opinions of the student nurses about their experiences during their clinical accompaniment in the selected hospital?”

3.3.1.1 Population

A population in this context is defined as “all elements (people, objects, events, or substances) that meet the sample criteria for the inclusion in a study” (Burns & Grove 2007:549; Polit & Beck 2006:506). According to Holloway and Wheeler (2002:157), the population in a research study can be used to illuminate the phenomena under study. Du Plooy (2009:108) notes that a population refers not only to people, but also to groups, individuals and events.

In this study, the researcher made use of an explicit selection criterion for the inclusion of participants: all of those who were included had to be student nurses who had been placed in the hospital under study from authorised colleges, and they also had to be students who had been allocated to the hospital periodically during the year that preceded the study. The researcher was careful to include as much diversity as possible in the population in order to imbue the data with as much authenticity and variety as possible under the circumstances. The

researcher also sought authentic information that would assist her during the process of data analysis so that she would be able to make recommendations based on diversity at the conclusion of the study. It is for this reason that the research used three different groups of student nurses although they were all drawn from the same population throughout the study.

3.3.1.2 The sample and sampling

A *sample* is a subset of a population that has been selected for the purposes of a particular study (Burns & Grove 2001:40). The reasons why the researcher should select a purposeful sample are important in qualitative research: they enable the researcher to gain an in-depth understanding of the sample that has been selected. Such a sample is not used for the purposes of generalising the findings of a study – as would be the case in a quantitative research design (Burns & Grove 2001:352). Because it is not always possible nor feasible to involve *all* the members of a population in a research project, the researcher uses a sample subset of the total available population. When all the characteristics of this representative sample have been studied, they should be able to be generalised to the entire group which constitutes the population (Welman et al 2005:67). Certain events, experiences and incidences guided the researcher to select a relevant sample from the population. Thus the researcher selected a sample of student nurses from among those who had been placed in the hospital during the course of the year that preceded the study. The researcher knew that these participants would have acquired a certain amount of experience and practice in the clinical environment since they had been allocated for their last year by their respective colleges.

Sampling, according to Gbich (2003:68-69), consists of the process of selecting individuals, groups or texts for inclusion in a project. It is prompted by the desire of the researcher to illuminate the question under study and it is defined in terms of where and when the study will be conducted and who will participate in it (Sarantakos 2005:110). A qualitative inquiry typically focuses in depth on a very small sample (and possibly even on single cases) that fit the criteria for making their participation relevant. The ultimate reason for selecting an appropriate and representative sample is that it will enable the researcher to

assemble individuals who will be able to provide rich, textured and layered information about how they feel and think (De Vos et al 2006:304; Krueger & Casey 2000:70). In this study, the researcher used three focus groups of student nurses who had been placed in hospital wards from a variety of colleges, and one group of clinical facilitators.

Because the researcher also made use of a non-random sampling technique, she was not able to determine the size of the group in advance. She also possessed a limited amount of knowledge about the entire population (Neuman 2007:141). The participants were selected from the total number of student nurses who had been allocated by all the colleges to the hospital in the study. The clinical facilitators were also selected from different colleges in order to diminish the possibility of bias and to ensure representativeness.

The researcher also used a technique called “snowballing”. This is a method whereby the student nurses who had been selected were allowed to refer one or more cases from the total population for possible inclusion in the final sample (Morse 2000; Munhall 2001; Patton 2002).

According to Gbich (2003:68-69), sampling is a process of selecting individuals, groups or texts for inclusion in a project. Sampling is prompted by the desire to illuminate the question under study and so it specifies where and when the study will be conducted and who will participate in it (Sarantakos 2005:110). A qualitative research project will typically focus in in-depth manners on small sample (and even on single cases) that are relevant to the purpose of the study. By doing this, the researcher will be able to assemble individuals in the sample and will be able to describe how they *really* feel and think about the particular phenomena under study (De Vos et al 2006:304; Krueger & Casey 2000:70). In this study, the researcher used three focus groups of student nurses who had been placed in the hospital wards from authorised nursing colleges and one group of clinical accompanists who the researcher interviewed individually.

3.3.1.3 Data collection

According to Sandelowski (2000:338), the process of data collection in a qualitative research study is directed towards the "who, what and where of events and experiences". Focus groups are frequently used in qualitative research activities because they enable the researcher to obtain a broad range of information about the events and situations in which she or he is *interested (Sandelowski* 2000:338). In this study, the researcher used focus groups to obtain a broad range of information about student nurse experiences during the process of clinical accompaniment in the specified public hospital in Gauteng Province of the Republic of South Africa.

The core advantage of field research is the "presence of an observing, thinking researcher [who is] on the scene of [the] action" (Babbie 2007:324).

In this study, the three groups of student nurses were engaged in focus group interviews during three different sessions. A separate focus group of clinical facilitators from the hospital was interviewed by the researcher in a separate session. Andrew and Halcomb (2009:72-73) maintain that since focus groups provide an effective method of data collection, it is usually better if the group is of a smaller to moderate size so that all the members of the group will have opportunities to offer their unique contributions. The following sections describe the rationale and methods of a focus group.

(a) The "naïve sketch" method of data collection

In the room where the focus group was held, the researcher wrote an incomplete open-ended question in large letters on a large paper that was visible on the wall of the room where they were gathered. Before the start of the interview, the participants were asked to complete the sentence by writing down the two most important issues that concerned them most about student nurse accompaniment in a clinical environment. The participants were then given about ten minutes in which to write down their own ideas on the topic, after which the papers on which they had written, were collected by the researcher.

This method of data collection method is referred to as “a naïve sketch”. The researcher used the naïve sketch method to obtain descriptions of the personal experiences of the research phenomena while maintaining sensitivity towards the social and cultural context of the research group. The naive sketch is a method of data collection that is similar in some ways to the use of open-ended questions. One identifying characteristic of the naive sketch is that only *one* incomplete open-ended question is used for participants to complete in writing (Burns & Grove 1997:368).

(b) Focus groups

According to Babbie (2007:322), focus groups interviewing is one of the most commonly used qualitative methods of research because they allow participants to be both interviewed and observed at the same time by the researcher. Babbie notes that focus groups are based on a structured, semi-structured or an unstructured interview format. By making use of them, a researcher is able to interview several participants systematically and simultaneously.

De Vos et al (2006:299) describe focus groups as an interviewing method that allows the researcher to select participants according to certain common characteristics that they possess and certain collective activities with which they are all familiar. De Vos et al explain that, by using this method, a researcher creates a confidential and tolerant atmosphere in which participants can share perceptions, points of view, experiences, as well as their desires and concerns without the pressure being imposed by voting or by the necessity to reach a consensus.

(c) Reasons for using focus groups

De Vos et al (2006:300) advance three reasons for using the focus groups method in qualitative research. They describe the advantages of a focus group as follows:

- Focus groups represent a self-contained method because focus groups can serve as the principal source of data.

- Focus groups can be supplemented by other methods such as surveys.
- Focus groups are particularly useful and effective in multi-method studies.

Flick (2006:197) adds that focus groups are particularly valuable during the process of data collection because of the interactive spirit that is generated in the group and that "produce[s] data and insights that would be less accessible without the interaction found in a group".

According to Streubert Speziale and Carpenter (2003:29-30), focus groups are useful for the following reasons:

- Focus groups allow researchers to collect information on a designated topic in an informal setting.
- Focus groups have an "advantage of being inexpensive, flexible, stimulating, cumulative, elaborative, assistive in information recall, and capable of producing rich data".
- Focus groups are useful for discussion of topics that might be too controversial, uncompromising or even embarrassing to be discussed in an unmoderated open forum.

(d) The reliability and validity of the focus group method

Streubert Speziale and Carpenter (2003:30) explain the advantages of focus groups in terms of the following three points:

Stability – The membership of focus groups may be allowed to change with the each meeting.

Equivalence – Focus groups rely on the consistency of the moderator or coders where they are used in interviews. In such cases, one moderator should lead the discussion in all the groups and one researcher should play a predominant role in analysis.

Internal consistency – This aspect of focus groups emphasises the importance of having one team member who is able to take a "major responsibility for

conducting the analysis, [for] attend[ing] many groups and [for] debriefing sessions and [who is able] to communicate regularly with other team members during the process of analysis".

Streubert Speziale and Carpenter (2007:30) go on to describe the validity of focus groups by stating that "validity" is used to describe *content validity*, which refers to the extent to which the researcher is convinced about the veracity and reliability of the information that the participants impart. The fact that the interviews include the members of the group who are being exposed to similar backgrounds and experiences provide a means of checking validity when one uses focus groups or purposes of research (Streubert Speziale & Carpenter 2006:3).

(e) The planning of a focus group

De Vos et al (2006:303) are of the opinion that a researcher should plan focus groups around the participants, the environment and the questions that will be asked during the interview. The author states that if a researcher shares the rationale of the focus group with colleagues, they should be able to provide the researcher with valuable feedback.

The researcher followed the basic steps recommended by De Vos et al (2006:303) for conducting focus group interviews. She defined the purpose of the research as a collection of data about the experiences of student nurses during clinical accompaniment in a public hospital in Gauteng province and explained that the outcomes of the project would made in the form of recommendations that could be used as guidelines for the clinical accompaniment of student nurses in a public hospital.

She then obtained permission for the collection of data from the colleges that had placed student nurses in the public hospital for clinical accompaniment, described the public hospital in which the students had been placed, and the clinical accompanists and student nurses who were approached by the researcher to be participants in the study (De Vos et al 2006:303).

The participants had been enrolled as level 2 nurses in various nursing colleges. They were all at the second-year level of the two-year course had only been considered for membership of these groups because they had been placed in the hospital within the year previous to the commencement of this study (which was also their first year of training). The clinical accompanists included tutors from the various colleges in which the students had been enrolled.

Initially, researcher approached and briefed three students individually and these students thereafter acted as informants who identified one more student each until the whole group consisted of six members (Welman et al 2005:69). Three focus groups of six participants each were approached initially according to this method of sampling. Some group numbers were increased by students who are on the same level in their course of studies who were located by word of mouth and by networking. This selection method (also known as “snowballing”) continued until a point of redundancy or theoretical saturation had been reached (Burns & Grove 2005:374).

The researcher ensured that each of the participants was given whatever information they needed about the venue of the meetings (which happened to be a conference room of the nursing managers). She also indicated the time when the meeting would take place and said that refreshments would be served at the conclusion of each meeting. The researcher also emphasised her earlier assurance that all participants were free to withdraw from participation in the groups at any time whatsoever if they wished to do so without the possibility of them incurring any adverse penalty (De Vos et al 2006:305-306).

(f) Conducting the focus group

The researcher introduced the topic to the group after they had all assembled in the conference room as agreed at 10:30 (Welman et al 2005:2002). The topic for discussion was the experiences of the student nurses during their clinical accompaniment in the hospital.

The room in which the interviews were held was a quiet and comfortable room in the administrative area of the hospital, with good lighting, homely curtains on

large windows – all of which contributed towards a relaxed and informal atmosphere. The researcher also made sure that a notice containing the words “Silence please, meeting in progress” was placed on the door so that the discussion groups were unlikely to be disturbed (Burns & Grove 2005:189).The office phone was disconnected by permission of management and the secretary notified the main switchboard that all calls to the conference room should be directed to her office. The researcher seated all the participants around in a circle, in such a way that each of them had a full and equal view of all others (Burns & Grove 2005:188).

The researcher then briefly introduced a session and asked each participant to give her selected name or her nom de plume or code name for use in the interview (if that was what they preferred to do). Each name was then inscribed boldly with a dark marking pen on a sheet of paper that was set up in front of the relevant participant. This guaranteed that anonymity would be maintained when the proceedings were recorded (Burns & Grove 2005:189).

The researcher explained to the participants that she was conducting interviews for the purpose of gathering data on the topic about which they had already been informed, and assured the participants that the information that was gathered would be treated confidentially by all the participants – including the facilitator herself (De Vos et al 2006:295). Each interview was allocated a duration of one and half hours (Neutens & Rubinson 2010:124), after which cold drinks, biscuits and chips were served to all the participants and an informal off-the-record discussion was held about what all of them thought about the interview for another fifteen minutes.

With all the discussions, the participants agreed that the researcher should be allowed to record the responses on paper and also by means of a tape recorder for purposes of back-up. Among the ground rules that the group set and agreed to, was the non-usage of cell phones, allowing one speaker at a time to speak without interruption, the encouragement of the full participation of all members of the group, and the requirement that all contributions should be spoken audibly (Welman et al 2005:202).

Once again, before the commencement of the interview, the researcher reminded the group that the participants were allowed to withdraw their participation at any time for whatever reason and that their withdrawal would not incur any kind of penalty or disadvantage on participants (Burns & Grove 2005:184).

The facilitator then asked open-ended questions and listened to the responses of the participants without showing any kind of emotion, whether negative or positive. But, at the same time, the researcher displayed interest and understanding in the responses made by each participant. While the researcher made minimal use of verbal and non-verbal cues as she sought to facilitate responses, she also asked for clarifications (where necessary) and responses for further information in those cases where she thought that such information would be useful (De Vos et al 2006:295).

At the end of each interview, each individual participant was asked to make a personal closing statement that none of the other participants were permitted to challenge (Welman et al 2005:2002). The researcher then explained yet again how the information would be used: for the formulation of guidelines to facilitate the clinical accompaniment of student nurses in public hospital settings and to contribute any new information to what was already known by scholars about this topic from the conclusions and recommendations that she would make in the study (Ulin, Robinson & Tolley 2005:95).

3.3.1.4 Data analysis

Streubert Speziale and Carpenter (2003:36) argue that data analysis begins when the process of data collection is initiated. According to Streubert Speziale and Carpenter, since data collection requires researchers to be immersed in the data that they collect, they need to maintain and review their records continually in order to discover additional questions or themes as they proceed with their interviews and observations of the participants. To elucidate the meanings of the concepts that emerged, the researcher observed, listened and immersed herself completely in the scenarios described during the process.

Welman et al (2005:211) agree that detailed notes (field notes) need to be made during interviews, and that these notes should be made by hand and tape-recorded. Welman et al then recommend that the researcher should process these field notes and write them up before she or he edits them for accuracy. It is during this phase that the researcher should also add whatever comments occurred to her or him so that they can be taken into account during the later phase of data analysis.

Qualitative content analysis has frequently been applied to sets of data in nursing and education research (Graneheim & Lundman 2003:105). During this process, the raw data is carefully sorted in terms of themes, categories, sub-categories and is duly coded with predetermined codes that the researcher has invented to indicate the current themes and points of interest. After the data has been collected, it is sent to an independent coder who is already familiar with the codes that are being used in the qualitative research.

The researcher made use of the following five phases or steps during the data analysis process:

- ***Step 1 – Familiarisation and immersion***

This step includes the development of ideas and theories about the phenomenon under study. It begins with a collection of data (Terre Blanche, Durrheim & Painter 2006:322-323). By making use of this step, the researcher was able to obtain a preliminary understanding of the meaning of data by the time the data analysis had been performed. Once the data analysis had been performed, the researcher reviewed her field notes and interview transcripts once again and made notes and comments, drew diagrams and brainstormed to ensure deep immersion.

- ***Step 2 – Inducing themes***

Terre Blanche et al (2006:323) describe *induction* as moving from general rules to specific instances. The organising principles that underlie the material have to be worked out from the data at hand. Firstly, the language used by the participants has to be used to label the categories that had been identified. Secondly, the researcher moves beyond the stage of summarising by focusing

on the processes, functions, tensions and contradictions inherent in the data. Thirdly, an optimal level of complexity has to be created by working on a few themes with several sub-themes under each heading. Fourthly, the researcher has to search for other themes that may still be embedded in the data, and, finally, the researcher has to ensure that she has not lost her focus of the central questions and problems that gave rise to the study in the first place. Although themes emerged from the data, it is absolutely essential that they should have a direct bearing on the research question (Terre Blanche et al 2006:323).

- ***Step 3 - Coding***

Terre Blanche et al (2006:324) describe *coding* as the breaking up of data into analytically relevant units. Different sections of data are then identified by means of codes and are matched with one or other of the themes that have been identified. All phrases, lines, sentences and paragraphs are coded. No code should be regarded as final or written in stone because they may change as further sub-themes are identified.

The data were transcribed verbatim from the tape recordings and the field notes that the researcher made during the interviews (Andrew & Halcomb 2009:188). The researcher then gave herself sufficient time in which to immerse herself in the data so that she would be completely familiar with all its elements and be able to reflect upon these elements and make connections between them. The researcher then coded and analysed the data by grouping similar ideas or themes into categories, and elaborated on the data by breaking it down into smaller areas under the heading of sub-themes (Polit & Beck 2006:473). Finally, the researcher interpreted and checked the data. According to Stephens (2009:101), qualitative data analysis involves a circular (reiterative) process of describing, classifying and connecting codes and themes that eventually result in the formulation of classes and categories.

- ***Step 4 – Elaboration***

In the stage of elaboration, the themes are examined and explored even more closely (Terre Blanche et al 2006:326). Steps 2 and 3 result in the creation of themes and coding of all the data that is obtained. They also result in the arrangement of the sequences of the data that have been obtained in a linear or chronological order. In the phase of elaboration, some of the themes that had been grouped together in the previous two steps might be found to be redundant, and this could result in the creation of new themes and sub-themes. Elaboration therefore constitutes an even more thorough analysis of the data that will allow the researcher to revise the details of the coding system should that prove to be necessary. The researcher therefore kept on coding, elaborating and recoding the data in reiterative patterns until no further significant insights or patterns emerged.

- ***Step 5 – Interpretation and checking***

Interpretation and checking are the final steps in the data analysis. These result in a written account of the study by making use of the thematic categories that had been identified. Any weaknesses in interpretation are remedied by re-examinations of the data and interpretations that the researcher has given to them (Terre Blanche et al 2006:326). It is at this stage that any prejudices on the part of the researcher – or any questions or doubts about her or his objectivity – should be identified in conjunction with the possible effects that this might make on the final outcomes of the study. The researcher discussed her interpretations with other experts and peers as a way of checking the accuracy of her interpretations.

3.3.1.5 Measures to ensure trustworthiness

According to Streubert Speziale and Carpenter (2007:49), a criterion or principle of good qualitative research resides in trustworthiness and in the neutrality of the findings and the decisions that characterise the study. Streubert Speziale and Carpenter are especially insistent that *rigouor* is important in qualitative

research, and they point out that this can be discerned from the places where the researcher places his or her emphases and the manner in which she or he confirms the data and its interpretation. Streubert Speziale and Carpenter also argue the goal of rigouor in qualitative research is to accurately represent the experiences of the participants in the study and that this is achieved by means of a persuasive attempt to convince other properly qualified people about the importance of the enquiry in progress (Streubert Speziale & Carpenter 2007:49).

(a) Credibility

Certain procedures have to be used to establish *credibility* (Babbie 2004:277). Credibility reflects the degree of confidence that a researcher and other experts on the subject have with regard to the findings that had been made and the plausibility of the experiences of the participants in their lived context. It is in such ways that credibility is identified from a coherent description of the phenomena.

Polit and Beck (2008:541) point out that credibility involves two main activities: “Firstly, the carrying out [of] the study in a way that enhances the believability of the findings and, secondly, taking steps to demonstrate credibility to external readers”.

In this study, the researcher assumed that the tangible reality that she was measuring represented an accurate interpretation of the experiences of the student nurses during their periods of clinical accompaniment (Streubert Speziale & Carpenter 2003:38).

Polit and Beck (2008:550) describe the credibility of the researcher as a strategy to increase the overall credibility of the research study. Since Polit and Beck define the researcher as an *instrument* for data collection, the researcher’s qualifications, experience and reflexivity are all relevant to establishment of confidence in the data. Patton (2002:552) adds that a researchers’ credibility depends on training, experience, her or his so-called “track record”, her or his status in the profession, and on the quality of self-presentation.

The researcher used the following strategies to ensure credibility:

- Prolonged engagement
- Persistent observation
- Triangulation
- Referential adequacy
- Member checks
- Peer review and debriefing

- **Prolonged engagement**

Polit and Beck (2008:542) note that prolonged engagement is an important step in establishing the rigour and integrity inherent in any kind of qualitative research. The authors emphasised the necessity to invest a sufficient amount of time in the collection of data in order "to achieve in-depth understanding of the culture [and] the language of the views of a group under study, [to] test misinformation and distortions, and to ensure saturation of important categories". The researcher engaged with the different focus groups of student nurses until she had reached the data saturation point and had established a firm degree of trust and rapport between herself and the participants. In turn for engaging in these activities, the researcher obtained a huge amount of rich, textured and richly layered information.

- **Persistent observation**

The proper and credible collection of data requires an enormous amount of persistent and focused observation. This kind of attention and observation "refer to the researcher's focus on the aspects of a situation that are relevant to the phenomena being studied" (Polit & Beck 2006:333). The purpose of persistent and meticulous observation, according to Lincoln and Guba (1985:304), is to "identify those characteristics and elements in the situation that are most relevant to the problem and [the way in which one focuses] on them in detail".

Consistency in analysis, interpretation and in searching for what is relevant and in excluding what is not relevant was the method that the researcher utilised in her examination and analysis of the data.

- **Triangulation**

Triangulation refers to the use of multiple points of reference and observation to draw conclusions about what constitutes the truth. The purpose of triangulation is to "overcome intrinsic bias that comes from single-method, single-observer and single-theory studies" (Polit & Beck 2008:543; Denzin 1989:313). The researcher adds that triangulation helps one to create a more complete and contextualised portrait of the phenomenon under study. Denzin (1989:313) note that there are four types of triangulation: *data triangulation, investigator triangulation, method triangulation* and *theory triangulation*. The researcher describes only two of these types for the purpose of this study.

- **Data triangulation**

Data triangulation includes the use of multiple sources of data for validating conclusions. There are three types of data triangulation and they involve time, space and person.

- Time triangulation: This refers to "collecting data on the same phenomenon at different times, day or year".
- Space triangulation: This refers to the "collection of data on the same phenomenon in multiple sites for cross-site consistency".
- Person triangulation: This refers to the "collection of data from different types or levels of people".

- **Method triangulation**

Polit and Beck (2008:543) further describe the use of multiple methods of data collection about same phenomenon. In a quality research study, the researcher assembles a rich blend of unstructured data collection by means

of, for example, interviews, observations and documents that enable her to understand the phenomenon more comprehensively.

In this study, the researcher opted for the collection of data from different points of view and followed up the questions that arose in different ways. The “different sources” that were used were the different students who were involved in the study.

- **Referential adequacy**

Lincoln and Guba (1985:313) note that the raw data that has been collected must be sufficiently adequate and ample to permit detailed analysis and interpretations. The researcher therefore made use of a tape recorder to document her findings and to function as a backup method for the enormous amount of data that emerged during the discussions. The use of this method was discussed among the participants and agreed to by all the participants.

- **Member checks**

Polit and Beck (2008:545) note that member checks constitute an important technique for establishing the credibility of qualitative data. Polit and Beck also point out that the use of member checks allow a researcher to provide feedback to the participants about emerging interpretations and this is also a method of soliciting participant reactions. Member checks therefore constitute an ongoing action during research, and it is sometimes performed in writing.

In order to collect additional volunteer information and to summarise the first step in data analysis, the researcher consulted the sources of information mentioned by the participants. In this way, she was able to assess the overall adequacy of the data (Babbie 2004:277). For a qualitative research to be transferable, it needs to be *dependable*. The researcher also supplied the participants with feedback in the summaries which she made at the conclusion of sessions.

- **Peer review and debriefing**

Peer review and debriefing are strategies for enhancing the quality of research through the use of external validation. The strategy evolves when sessions are held with peers so that they can be given opportunities to review, question and familiarise themselves with every aspect of the enquiry. During the review, the researcher presented written or oral summaries of the data categories that she had created, the themes that had emerged, and the interpretations of the themes that she had made. In some cases, see also played back portions of the taped interviews for the purpose of making her peers more familiar with the original content of the data (Polit & Beck 2008:548).

(b) Confirmability

Confirmability reduces the degree on subjectivity inherent in the study and adds the idiosyncratic kind of objectivity that can be created in qualitative studies. In this study the researcher used Guba's model to ensure a degree of rigour without sacrificing the relevance of the study. In the opinion of Streubert Speziale and Carpenter (2003:38), Guba's model is comparatively the most developed model that is available for qualitative research.

According to De Vos et al (2006:46) this criterion depends on the achievement of truth value and applicability. The findings and research procedures that were used had to be rendered free from bias by the researcher through decreasing the distance between her and the student nurses whom she studied. This was only achieved after prolonged contact with the students and lengthy periods of self-observation and self-analysis. This neutrality that is being described here is that of the data – as opposed to that of the researcher herself.

(c) Transferability

In qualitative research, a researcher needs to account for contextual factors when she transfers data from one situation to another. The goal of qualitative researchers is to produce data that is conceptually representative of the people studied within a specific context (Ulin et al 2005:27).

Once this degree of confidence has been achieved, the researcher can proceed to present a sufficient amount of descriptive data to allow extrapolation of the findings to larger populations in other similar contexts and settings (De Vos et al 2006:46).

(d) Dependability

Ulin et al (2005:26) point out that the research process should be consistent and should be carried out with careful attention to dependability. The researcher adds that the research questions should also be clearly formulated and logically connected to the research purpose and design of the study.

After paying attention to the achievement of applicability, the researcher felt that the findings in her study about the experiences of student nurses during clinical accompaniment would remain reasonably stable over time with similar subjects in similar contexts and environments (Babbie 2004:278; Ulin et al 2005:26).

3.3.2 Step 2

The research question for step 2 of phase 1 was: "What are the views of the clinical facilitators of the experiences that student nurses undergo during their clinical accompaniment in the selected hospital?"

The objective of step 2 of phase 1 was to explore the views of the clinical facilitators pertaining to the experiences of the student nurses during their clinical accompaniment in the selected hospital.

3.3.2.1 Sample and sampling

Definitions of the concepts of *sample* and *sampling* were supplied in section 3.3.1. The researcher followed the sampling guidelines that had been developed by Curtis, Gesler, Smith and Washburn (2006:1003), and these are set out in figure 3.1:

"The sampling strategy should stem logically from the conceptual framework as well as from the research questions being addressed by the study.

The sample should be able to generate a thorough database on the type of phenomena under study.

The sample should at least allow the possibility of drawing clear inferences from the data; the sample should allow for credible explanations.

The sampling strategy must be ethical.

The sampling plan should be feasible."

Figure 3.1: Sampling guidelines

(Source: Adapted from Andrew & Halcomb 2009:77)

The researcher chose to include another group apart from the student nurses in her research. This group consisted of the clinical facilitators who were involved in and responsible for the professional accompaniment of the students as well as for the staff development of professional nurses who accompanied the students in the hospital as clinical facilitators.

The reason why the researcher included these participants in the research population was because the researcher was of the opinion that this population would be able to further illuminate the phenomena under study (Holloway & Wheeler 2002:157). These people represented the fourth group of participants in this study, and the researcher felt that they would be able to provide a forum that would lead to further insights, inspire additional observations and patterns of response. She also thought that they would be able to enrich the diversity of opinions that had already been be revealed by the first three student groups (Padget 2004:182). These participants were all adult registered nurses who had served on the staff of the nursing colleges and the hospital enrich the study was conducted for periods of *more than ten years*.

3.3.2.2 Data collection

The research setting for the collection of data was a quiet room that was situated inside the management area. The naturalness and neutrality was deliberately chosen to eliminate any kind of anxiety or irritation (Flick 2006:260). The researcher and her participants sat in a circle so that each participant had an equal view of all the other individuals who were present in the room (Stephens 2009:96). After the researcher had reintroduced the study and the topic and completed the formalities connected with informed consent, she once again explained the purpose of the research and asked the participants to introduce themselves individually to the group. The researcher explained her purpose in using a tape recorder that it served as an additional backup to the note-taking method that she was using, and that it would enable her to capture and verify all aspects of the discussion. The participants allowed the researcher to write notes and use a tape recorder during the interview. The researcher then emphasised the necessity for confidentiality and asked the participants not to use their real names. But she gave them the assurance that if they did use their real names, she would delete their names from the written or taped record directly after the interview had taken place. She then posed the open-ended question and repeated its terms for purposes of clarification. The participants were then asked if they would prefer to write down their thoughts or whether they would prefer to continue the proceedings by means of verbal face-to-face discussions. They preferred to proceed to the interview.

3.3.2.3 Data analysis

The researcher then captured the data that was produced during the discussions by means of her own written notes and the recordings made by the tape recorder. She subsequently analysed all this data by following the same process that is described in paragraph 3.3.1.4.

3.3.2.4 Strategies that the researcher applied to enhance trustworthyness

The researcher engaged the clinical facilitators in a discussion in such a way that they were motivated to give their inputs spontaneously and enthusiastically. This focus group interview was verified by means of triangulation, which is one of the strategies used to enhance the *trustworthiness* of any research. The clinical facilitators then proceeded to discuss the facts that constitute truth and the various means that one can use to minimise or eliminate bias (Polit & Beck 2008:543; Denzin (1989:313). The significance of this group was that it allowed the researcher to collect data from experienced and professional practitioners who were very different in their outlook because of their experience, knowledge and wisdom from the student nurses who constituted the first three groups. The clinical facilitators discussed the various ways in which they practised the clinical accompaniment of the student nurses in clinical settings in the hospital and they also provided input into the formulation of guidelines that might be useful for professional nurse educators who were charged with responsibility for the clinical accompaniment of student nurses in the future.

Phase 2: Evaluation phase

3.3.3 Step 1

The research question for step 1 of phase 2 was: What recommendations and observations can students make about their experiences during their clinical accompaniment in the selected hospital?

The research objective for step 1 of phase 2 was to describe the recommendations and observations of student nurses about their clinical accompaniment in the selected hospital.

3.3.3.1 Sample and sampling

The researcher used the same sample and sampling techniques that are outlined in paragraph 3.3.1.2. The three groups of student nurses were used throughout the study.

3.3.3.2 Data collection

The researcher used the naïve sketch method and a focus group discussion. The full discussion about data collection is described in paragraph 3.3.1.3.

3.3.3.3 Data analysis

The discussions were recorded in writing and by means of the tape recorders. The analysis of the data is discussed in full in paragraph 3.3.1.4.

3.3.3.4 Strategies to enhance trustworthiness

The strategies that the researcher used to enhance trustworthiness are discussed in detail in paragraphs 3.3.1.5 and 3.3.2.4.

3.3.4 Step 2

The research question for step 2 of phase 2 is: What recommendations have been made for the development of a tool to serve as a guide during the clinical accompaniment of student nurses in the selected hospital?

The research objective for step 2 of phase 2 was to make recommendations for the development of a tool that would be able to serve as a guide during the clinical accompaniment of student nurses in the hospital.

The researcher followed the same sample and sampling techniques, forms of data collection, data analysis and strategies to enhance the trustworthiness as described in paragraphs 3.3.3.1 to 3.3.3.4.

Phase 3: Recommendations

3.3.5 Step 1

The research question for was: What do the student nurses expect from their clinical facilitators as they perform their functions as clinical facilitators during the process of clinical accompaniment in the hospital?

The research objective for step 1 of phase 3 was to explore, describe and identify what the student nurses expected from their clinical facilitators during clinical accompaniment.

3.3.5.1 Sample and sampling

The researcher used the same sample and sampling techniques that are discussed in paragraph 3.3.1.2. The researcher used the same three groups of students throughout the study.

3.3.5.2 Data collection

The researcher made use of the naïve sketch technique and a focus group discussion. A full discussion about data collection appears in paragraph 3.3.1.3.

3.3.5.3 Data analysis

The researcher made notes of all the discussions that took place both in writing and by means of the tape recorders. A discussion of the methods that the researcher used for data analysis appears in full in paragraph 3.3.1.4.

3.3.5.4 Strategies that the researcher used to enhance trustworthiness

The strategies that the researcher used to enhance trustworthiness are discussed in detail in paragraphs 3.3.1.5 and 3.3.2.4.

3.3.6 Step 2

The research question for step 2 of phase 3 is: What recommendations can be made towards the development of a tool serving as a guide during clinical accompaniment of student nurses in a selected hospital?

The research objective for step 2 of phase 3 was to make recommendations that would serve for the development of a tool that could be used as a guide for professional nurse educators during the process of the clinical accompaniment of student nurses in state hospitals in South Africa.

The researcher performed the actions required for assembling a sample and for the sampling process, for data collection, for data analysis and for strategies to enhance the trustworthiness in the same way that is discussed in detail in section 3.3.2. All of the participant groups contributed towards suggestions for the formulation of guidelines for the clinical accompaniment of student nurses in public hospitals.

3.4 ETHICAL CONSIDERATIONS

The researcher paid particular attention to the following ethical principles that guided the progress of this study: the maintenance of privacy, voluntary participation, anonymity, confidentiality, informed consent, protection of the participants from harm and the considerations that governed the involvement of the researcher. These factors formed the basis for cooperation between the participants in the researcher and ensured the acceptance of the researcher by the participants (Bless & Higson-Smith 2000:100-101).

According to Neutans and Robinson (2010:56-57) and Boswell and Cannon (2007:51-52), a commission was established to consider and make recommendations about the ethical principles that should govern all research that is undertaken under the auspices of a university or research institute. Such principles should guarantee the protection of the “vulnerable” participants – and especially of children and participants who are under 18 years of age. The

commission made their recommendations in a report that is known throughout the academic world as the Belmont Report.

The report includes various conditions and definitions that the researcher used in her study to protect the participants who were all student nurses who had been placed in a public hospital for all the purpose of gaining experience in clinical accompaniment under the supervision of professional nurse educators.

The researcher applied the principle of beneficence throughout this study because the research has the potential of exerting an effect on the community at large, and it is incumbent upon researchers to recognise the various obligations that are inherent in any human research projects with long-term implications for society at large.

The researcher applied the principle of *justice* because this principle protects the "vulnerable" and is concerned with the individual right of every participant to be treated in an ethical and correct manner.

The Belmont Report recommended that each individual who participates in a study should be given what is due to him or her (Boswell & Cannon 2007:51). The description of "due to him or her" may be elucidated in the following way:

- An equal share or the means of justice should be accorded to each participant.
- Each participant should be treated according to his or her individual needs.
- Each participant should be treated according to his or her individual efforts.
- Each participant should be treated according to the contribution that he or she makes to society.
- Each participant should be treated according to his or her individual merit.

The researcher took into account the potential vulnerability of all the student nurses by giving them as much information about the study beforehand as they

needed, and by informing them that they were completely free to withdraw their participation from the project at any time without explanation if they wish to do so, and that any such act would not elicit any kind of penalty or retribution. The researcher ensured that the ages of the each of the participants were known to her so that she would be able to apply the principles of autonomy and beneficence.

3.4.1 The right to privacy

Bless and Higson-Smith (2000:100) point out that no person should be subjected to any kind of research unless they have freely given their informed consent to being such subjects of research before the research commences. In this case, the students were asked whether they were willing and happy to participate in the study. The researcher asked them this question so that any form of discomfort or potential psychological harm might be avoided from the onset. Since participation was entirely voluntary, all the students were told that they had an inalienable right to withdraw from the project at any time without any explanation, without incurring any penalty or disqualification whatsoever (Davies 2007:45). They were also informed of their right to refuse to divulge any kind of information about themselves, and at the researcher would prefer to use coded names during the interview. All of the participants were above eighteen years of age and were therefore treated as adults. Both the potentially positive and negative aspects of participation were clearly indicated to them before the study commenced.

3.4.2 Voluntary participation

Participants were informed that they could revoke their participation at any time before or at any stage during the study, and they were assured that all information that had been gathered about them or from them would be destroyed if they decided to withdraw from the participation. The “privacy” referred to in these ethical principles refer to *personal privacy* (Bless & Higson-Smith 2000:100).

3.4.3 Principle of justice

It was the researcher's responsibility to maintain a reasonable, non-exploitative and fair procedure in allocating the potential costs and benefits of the study among the group as a whole (Murphy & Dingwall 2003:149-152). The researcher ensured that the research report was as clear, accurate and as objective as possible and recognition was given to the participants in a form of gratitude that the researcher extended to them on account of their willingness to participate in the study.

3.4.4 The right to anonymity

Rubin and Babbie (1999:62) describe *anonymity* in research as the methods that a researcher uses to ensure that no participant in the study can be identified from any of the responses that are given by participants. Participants were also given the option of preserving the right to have their names removed from the record and the identity of all other employees and participants to be kept anonymous. The researcher therefore used numbers and codes instead of the real names of the participants to openness and progress and to avoid false or biased responses and anxiety and emotional distress. This right to anonymity is applied together with confidentiality, and both include meticulous efforts to handle information in a confidential manner. No hidden apparatus such as video cameras and audio recorders were used during the research process. The explicit permission of all the participants was obtained for the written and tape records that were made of all scheduled proceedings.

3.4.5 Beneficence

Murphy and Dingwall (2003:149-152) emphasise the obligation of a researcher to ensure the well-being of all participants and the fact that possible benefits during research should be maximised while potential harm to participants should be minimised or entirely eliminated. The participants were informed beforehand about the possible impact of the study in clear and unambiguous terms. Any vulnerable participants were looked for before the research began for the purpose of eliminating from the interview groups – none were identified.

Participants were assured that the results of the study would be given only to their respective colleges. Their names would not appear in any of the documents of the study. The system of codes was implemented and maintained throughout the study and neither the researcher nor any of the participants were allowed to divulge the names of other participants or the study results to anybody at all. This was done in order to minimise risks and avoid harm.

3.4.6 Informed consent

Welman et al (2005:201) state that explicit permission, indicating the agreement of participants to participate in the study, should be obtained from all by the researcher after the participants have all been truthfully and clearly informed about the purpose of the study (see attached Annexure D for a copy of the letter of informed consent that was distributed among participants).

3.4.7 Protection from harm

The participants were informed that they would be protected from any form of physical or psychological harm during the research procedures (Welman et al 2005:201). Harm can be physical, emotional, social and financial (Polit & Beck 2006:87). In this study, the researcher gave the participants the necessary information about the study well in advance and allowed the them to ask questions about any concern. In this way, the researcher eliminated any possible source of anxiety and psychological harm. In addition to those, the researcher took great trouble to phrase the research questions in non-threatening and clearly comprehensible terms.

3.4.8 The involvement of the researcher

All researchers should guard against treating their participants as “objects”. The means, in practice, that research participants should never be manipulated in any way whatsoever. Respondents should always be treated as human beings with an inalienable right to maintain their human dignity, and at no stage should any unethical tactics be used to obtain any kind of information (Babbie 2007:325).

The creation of full and accurate notes is vitally important in all research projects. The researchers should take notes while observing and listening to the discussion of the participants or else the researcher should write up the notes as soon as possible after the conclusion of the discussions. Both empirical observations and their interpretations should be included in the notes because this represents what the researcher “knows” and what she “thinks” has happened (Babbie 2007:325).

The researcher not only recorded the data about their experiences of accompaniment as they were being given by the student nurses during the discussion sessions, but she also included her own interpretations of what she had observed during the focus groups interviews. She did this in the most unobtrusive possible manner in order to avoid affecting the behaviour of the students while they were being observed. The researcher’s notes therefore represent a sample of her most important observations (Burns & Grove 2005:376).

Schreier, Wilson and Resnik (2006:6) suggest that any individual researcher should follow the best practices guidelines that govern record keeping. These guidelines include planning, collecting, recording and analysing research. When the six interviews had been completed, the researcher collected the six tapes, the two dictaphones and the field notes that had been utilised and created during the interviews and kept them under lock and key while she was engaged in the process of data analysis and the reaching of conclusions are about the study. Two tape recorders and six tapes used functioned well during the course of the focus group discussions. The researcher will make any of these documents available to authorised and qualified researchers on request.

3.5 CONCLUSION

Chapter 3 described the research design and methodology. The researcher obtained the data by means of focus group discussions with the intention of extracting any useful responses that might be relevant to the research problem from participants who had been specifically selected and briefed about the purpose of this research. An independent coder and the researcher together

performed the data analysis. The participants were assigned random codes in order to ensure that their confidentiality would never be violated.

Chapter 4 describes the data analysis of this study.

CHAPTER 4

Data analysis

"Learning is not attained by chance; it must be sought for with ardour and attended to with diligence."

Abigail Adams

4.1 INTRODUCTION

Chapter 3 described the research methodology used in this study. This chapter discusses the data analysis and explains the findings concerning the problems experienced by student nurses during their clinical accompaniment in one public hospital in the Gauteng Province of the Republic of South Africa.

The researcher collected all her primary data from four focus group discussions, described in chapter 3. The numbers of participants who were involved in these focus groups are summarised in table 4.1.

Table 4.1 Focus groups

Group	Number of participants
Group 1	Seven participants (student nurses)
Group 2	Ten participants (student nurses)
Group 3	One participant (one student nurse)
Group 4	Three clinical accompanists (professional nurse educators) who were permanently appointed in the public hospital in which this study was conducted.

All student nurses who participated in the study had been allocated to the hospital in 2007, from authorised nursing colleges in terms of the SANC regulations that govern clinical accompaniment.

The objectives of this study were as follows:

Phase 1: Step 1 – To conduct an inquiry into the views and opinions of student nurses about th11eir experiences of clinical accompaniment in the hospital environment

Phase 1: Step 2 – To conducting an inquiry into the views and opinions of the professional nurse educators (the clinical accompanists) who accompany the student nurses in clinical settings in the designated hospital

Phase 2: Step 1 – To identify and discuss, from the point of view of the student nurses, what could be done to improve their experiences of clinical accompaniment in the clinical settings of the designated hospital

Phase 2: Step 2 – To identify and discuss, from the point of view of the professional nurse educators (the clinical accompanists), what could be done to improve their experiences of clinical accompaniment in the designated hospital in an environment

Phase 3: Step 1 – To explore, describe and discuss the problems connected with the experiences of the student nurses and the clinical accompanists during the processes of clinical accompaniment in the designated hospital

Phase 3: Step 2 – To make recommendations about the development of a tool that might be used as a guide for the clinical accompanists of student nurses in the clinical settings of the designated hospital

The researcher facilitated all the focus groups according to a predetermined schedule until data saturation had been reached. The researcher knew when the saturation point in each case had been reached because the participants began to offer the same information over and over again in spite of variations in the questions (Polit et al 2001:470).

The process of data analysis only commenced once all the data had been properly collected, transcribed and verified for accuracy. The researcher herself analysed the data manually by immersing herself in the data over and over again. The researcher organised the data into recurrent themes by means of comments and codes. Then she re-examining the themes that had emerged and

by arranging these themes into a higher-order categories that provided an explanatory overview of the meanings, opinions and attitudes that were embedded in the raw data (Polit et al 2001:381).

4.2 CODING

As was described in the previous chapter, the researcher recorded the data from the focus group interviews both manually (these constituted the field notes), and by means of tape recordings that were used as a form of backup (Andrew & Halcomb 2009:188). The researcher had ample time to immerse herself in data collected in this way, to reflect upon it over a period of time, and to scrutinise the purpose of eliciting the recurrent themes that were embedded in the record of the discussions. She then coded and analysed the data by clustering similar themes or ideas into categories, and elaborated these categories by breaking them down into sub-themes in those cases where this procedure clarified the implications of the main theme (Polit & Beck 2004:473). After the researcher had checked the data that she had assembled in this way, she embarked on the process of interpretation and analysis. According to Stephens (2009:101), a qualitative data analysis involves one in a circular (reiterative) process of describing, classifying and connecting data so that they can be incorporated into a number of different classes and categories, each of which is descriptive of a particular main theme.

During the process of data analysis, the researcher identified the following three main themes:

- **Theme 1:** The clinical environment
- **Theme 2:** Learning opportunities for student nurses
- **Theme 3:** Student nurse accompaniment guidelines

Figure 4.1 provides a summary of the data analysis. During the process of data analysis process, the researcher identified three main themes, categories, clusters and sub-clusters (as can be seen in the figure 4.1).

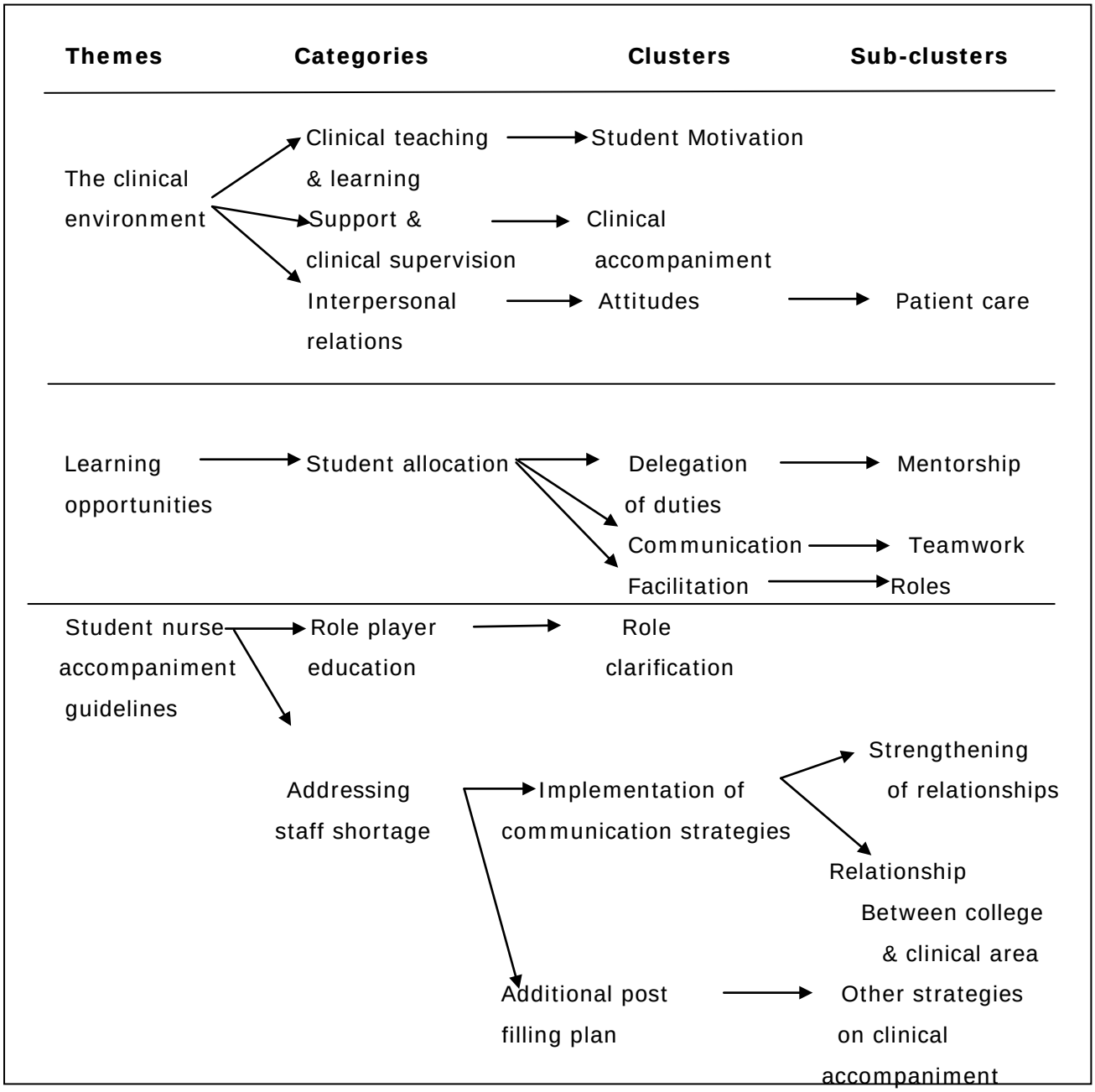

Figure 4.1: Summary of the data analysis

4.3 THEME 1: THE CLINICAL ENVIRONMENT

Chan (2004:665) defines "the clinical environment" as the context or setting that surrounds the student nurse while she or he is practising or providing nursing care. This definition is also applicable to all ranks of nurses and to the clients themselves because they all exist and function in the surroundings

within which the nursing care takes place in a health care institution.

The participants gave the following opinions about how they experienced and perceived the learning environment. (NOTE: In this case and in all other instances in which the researcher has quoted from what the students and nurse educators said during the focus discussion groups, the researcher has used the actual words of the participant. Any editorial additions that have been inserted for the sake of clarification are enclosed within square brackets).

"When students are accompanied, they are more relaxed."
"Students are seen as [being] compassionate by patients. They get attached to patients. Some patients view them as irresponsible."
"Students have a tendency of viewing others as [being] lower in experience than them."
"There is a lot of competition. Competition is good. It pushes performance higher."

An environment that is conducive to learning is a vital component of effective student nurse accompaniment (Chisari 2009:18).

Although any clinical environment should be conducive to effective learning, the reality of the situation in South Africa is that many clinical environments might be chaotic and troubled because they are essentially dysfunctional and inadequate. Students who are trained in such environments acquire a distorted vision of what it means to be a professional nurse, and often find themselves unable to master the knowledge and skills that they need to become effective nursing practitioners (Starr-Glass 2002:512-513; Sleutel 2000:4).

The clinical environment was extensively discussed in section 1.8.4 of this dissertation.

Table 4.2 The categories, clusters and sub-clusters that emerged from the theme: *The clinical environment*

Categories	Clusters	Sub-clusters
4.3.1 Clinical teaching and learning	4.3.1.1 Student motivation	
4.3.2 Support and clinical supervision	4.3.2.1 Clinical accompaniment	4.3.2.1.1 Patient care
4.3.3 Interpersonal relations	4.3.3.1 Attitudes	

The researcher discusses these categories, clusters and sub-clusters. In each case she supplies a range of quotations extracted from data to support her conclusions, and also (where applicable) corroborates her conclusions by means of quotations from the relevant literature.

4.3.1 Clinical teaching and learning

According to Quinn and Hughes (2007:371), advanced beginners *need* an adequate amount of support, supervision and encouragement from their supervisors, mentors and colleagues in the practice setting. Redus (1994:239) notes that the probability that a learner will succeed can be increased by the application of following seven principles of learning:

1. the establishment of clear and realistic outcomes
2. the devotion of an adequate amount of time to practical learning
3. the creation of a situation in which knowledge transfer takes place
4. information about whether or not the student has been successful (feedback)
5. a focus on becoming successful
6. the creation of opportunities for meaningful learning and skills acquisition
7. the encouragement of created and independent thoughts because of the proven correlation between ability and creativity

The student nurses were by and large of the opinion that they were able to work well in the clinics because there were some nursing sisters, doctors and other or junior nurses who were skilled in teaching. They asserted that these health care professionals were friendly and that they remained supportive throughout the

teaching sessions that characterise clinical accompaniment. But there are other students who noted that some of the health care professionals who were responsible for tutoring them in clinical settings were unhelpful and discouraging. They expressed their dissatisfaction with individuals and the system itself in the following words:

> " We do want to speak about the positive experiences but the negative points 'out-w-e-i-g-h' the positive ones."
>
> "People are different and not everybody is wrong. At times we must focus on the positive side."
>
> "Some nurses try to teach us but they are reprimanded."

All of the participants without exception expressed the opinion that there were too few professionals who functioned as role models and mentors in the wards. This absence of suitable role models and mentors contradicts the recommendations made by Quinn (2000:417), namely that qualified staff should be willing to supervise, mentor and assess student nurses in order to create clinical environments that are conducive to learning. One of the students expressed her perceptions of these deficiencies in the following words (which are representative of the opinions of the whole sample):

> "The staff treats us like non-human beings. They refuse to teach us in the wards. When some staff members teach us, they are told to stop wasting time. They are jealous and they forget that they were once student nurses."

The participant whose words have been quoted looked and sounded very angry when she made these statements. Therefore one may assume that the dysfunctional attitudes of the teaching and mentoring staff have given rise to a great deal of negative emotion among these student nurses. She confirmed that she was indeed very angry and was satisfied when the researcher reflected her (the researcher's) perception of the student's emotions.

"One other thing is the disappearance of the staff 'seniors and permanent', leaving students on their own. At the moment we are working under supervision."

"The seniors don't want to give us enough information; they say they don't know how to teach the students. By 'staff' we mean the sister-in-charge and other staff nurses who ask you to go and buy them something at the shop. And if you say 'no,' they say you have an attitude and [that] you will not be shown things that you don't understand."

"We are also made to work with patients with communicable disease without preventative treatment. We need treatment and protection, e.g. masks."

Most of the participants in the first two groups indicated that such forms of unprofessional behaviour were daily challenges in their experiences of clinical mentoring in the designated hospital.

"But at the end of the day we have to work hard for the sisters to sign for us. When they refuse and we report [them] to the clinical tutors, they will say, 'Keep on trying, my children, keep trying and be patient; they will sign for you', [and so] at the end of the day, you end up crying. You know it's like we are doing each other a favour. If we are not patient, we won't get it."

"If they say 'Do this', and you say, 'No, I can't', they say 'Oh you, you are in trouble'. But they never teach us. They make us give bedpans; [observe] vital signs… Those are the things [that] they are comfortable with."

"When they are at the trolley handing out medication, they send the student to the other ward to ask for medication for the patients."

"We are told to do 'ruk and druk' [the cleaning of the patients and the tidying of the ward], or to do [attend to] the vital data."

"At times, some staff members send us to buy chips at the canteen, and if we refuse, they tell us that they won't teach us. They treat us like their PAs [personal assistants]."

"If we watch a nursing procedure done by a staff member, we are called away to do another task or we are even sent to take or fetch tools. At times the staff member just stops doing the procedure."

According to the students, some of the ward sisters were willing to teach them. Such sisters would invite them to participate in teaching and learning sessions. Others would send them away to perform other tasks or give them more work to keep them occupied. One of the participants made the following remark about how they were missing opportunities to acquire indispensable skills:

"We actually miss [out] on the art of medication giving."

4.3.1.1 Student motivation

The students who participated in the focus group discussions were by and large of the opinion that most nurses are (by nature) good people. In general, they regarded the paediatric ward as a rewarding area in which to work and learn new skills. A study undertaken by Girot (1993:116) came to the conclusion that *caring* is the central core skill of nursing practice and that caring competencies should be acquired by all student nurses and nurses who are about to qualify for their professional registration. During the course of the focus group discussions, some student nurses also pointed out that they were taught how to provide good

care to their patients, and that this made them feel like “future nursing managers”. These sentiments are contained in the following quotes:

> “Sometimes I don’t blame the nurses. They are struggling, they are short staffed, they are running [about in an effort to supply all necessary] treatments, and here I am, wanting to know something. I do understand their frustrations.”
>
> “If they were working under good conditions, we would gain more.”
>
> “Patients are ‘nicer’. They make us feel like future matrons.”
>
> “Nurses are not bad. [But] you do have odd ones.”

4.3.1.2 Clinical accompaniment

According to Morton-Cooper and Palmer (2000:3) and Motlhale (1999:5), accompaniment has become a necessity because of the division that has been made between teaching student nurses theory and teaching them to put into practice what they have learned. Morton-Cooper and Palmer (2000:3) and Motlhale (1999:5) define accompaniment of students as the ability “to escort, attend, guide and coexist” with student nurses during their experience of clinical accompaniment.

In spite of this ideal, one of the students noted:

> “Procedures are good but people do what they like and are not disciplined.”

But the clinical facilitators had their own views about the difficulties inherent in the practice of student accompaniment in clinical settings:

"Clinical supervision differs according to training colleges. Some [clinical supervisors] are continuously present and interactive while others are never there. Ratios are a challenge."

"Staff development caters for student needs. Students are allowed to participate in clinical procedures. They are also allowed to participate in area management discussions. Student nurses are monitored by tutors who are overworked and [who are] not coping."

"Some facilitators need accompaniment themselves."

"During ward rounds, students stand at the back but are called to order. They are allowed to check files."

According to Quinn and Hughes (2007:359), clinical supervision can be defined as a "formal process of professional support and learning which enables the individual practitioner to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations".

The student nurses who were participants in the study needed to be supervised during their practice in clinical settings so that they would be able to acquire the necessary knowledge and competence to become competent professional nurses. But the participants claimed that they were insufficiently supervised during clinical supervision when they were required to perform procedures on patients.

4.3.2 Patient care

The focus group participants stated that the care given to patients in the hospital was good compared to the care that patients received in other hospitals.

> "The hospital offers expensive treatment which is costly at private hospitals. Operations are also cheaper, like [in] all the public hospitals."

4.3.3 Interpersonal relations

Reilly and Oermann (1992:143) maintain that mutual respect still exists between student nurses and their supervisors, and that student nurse supervisors needed to establish good rapport with their students. They also maintain that student nurse supervisors should be able to display personal warmth, caring behaviour, openness, and concern for their students (where necessary). The student nurse participants mentioned incidences of ineffective communication that had caused them to feel emotionally disturbed.

> "Staff pointing fingers at students is not right."
>
> "At times we [the student nurses] are shouted at in front of patients and we are called 'stupid'. Doctors blame nurses for what they have done themselves."

Participants said that the comments recorded made them feel angry.

> "Most cleaners and porters are rude, and they make you feel small."
>
> "The staff and students from other colleges call us 'dom dom' ["stupid stupid"] or call us by our college name [even though] we have our name badges on."

Searle and Pera (1995:258) assert that "to understand the nurse-patient relationship, one has to have a very clear idea of the roles of patient and nurse, and the obligations of the nurse in a society. It [the role of the nurse] should be a positive one and involve a rapport."

Participants agreed that the patients were respectful towards them and appreciated the care that the student nurses gave them. In the words of one of the participants:

> "We run for patient needs."

4.3.3.1 Attitudes

"The question of how a nurse is committed to a patient, or client, involves what it means to be a professional" (Searle 2000:295).

The student nurse participants displayed a good understanding of what the nurse-patient relationship should be during their clinical exposure. All these student nurses explained that they were serious about maintaining the professional relationship that they enjoyed with the patients under their care while they were in hospital. All the participants were amused by the following statement:

> "Some male patients ask us for [our] telephone numbers, but I tell them that they must first get well and be discharged, and then we can talk outside."

> "Patients are 'nicer' when they know that you are students. They appreciate and respect us."
>
> "They [the patients] call you 'nurse'; [they] say thank you when you help them; they call us "sister", "matrons". They make us feel like future matrons."
>
> "Sisters should control staff attitudes towards students. Staff must respect students and stop calling them names. To teach us correctly and not correct us in front of patients."

4.4 THEME 2: LEARNING OPPORTUNITIES FOR STUDENT NURSES

According to Dwyer, Deloney, Cantrill and Graham (2008:7), the first experience of learning clinical skills can be extremely frustrating for students who are passive by nature. In order to maximise learning opportunities and minimise levels of stress, some kind of innovative approach should be developed. It may be necessary for professional nurse educators and nursing sisters to teach students in smaller groups as they accompany them in clinical settings. Dwyer et al (2008:7) also emphasise that student nurses need to be closely supervised during accompaniment, and should be given immediate feedback about progress or errors when they are being taught particular nursing skills or practices.

The hospital in which the study was conducted offers opportunities for clinical practice to a number of authorised colleges with student nurses at different levels of achievement. This practice may limit the clinical exposure of students in general, especially when such exposure is linked to the discussions that should take place between the health care professional who is accompanying the students and student nurses in clinical settings. The clinical accompanists confirmed that doctors are generally regarded as good teachers, possibly because when wards are particularly busy, they simply send all the student nurses out.

The categories, clusters and sub-clusters that emerged under the theme labelled ***Learning opportunities for student nurses*** are summarised in Table 4.3.

Table 4.3 The categories, clusters and sub-clusters that were identified under the theme: *Learning opportunities for student nurses*

Categories	Clusters	Sub-clusters
4.4.1 Student allocation	4.4.1.1 Delegation of duties	4.4.1.1.1 Mentorship
	4.4.1.2 Communication	4.4.1.2.1 Teamwork
	4.4.1.3 Facilitation	4.4.1.3.1 Roles

4.4.1 Student allocation

The student nurse participants noted that they were not allowed to work in some of the departments due to an incident that had occurred with a previous group in the hospital. The allocation of students to practical areas is an essential part of their training in terms of the SANC regulations. Thus the education and services that are provided during the course of in-house hospital training, should be jointly planned by the authorities of the hospital and the colleges concerned. Arrangements should also be by both the hospital and the administrators of the colleges for implementing the continuous monitoring of standards of quality (Quinn & Hughes 2007:359).

> "We don't get the same treatment in the wards where we work with other students."
>
> "[In addition to this], it is not appropriate that the students from other colleges don't work night duty. The staff sleeps on night duty or [else they] chat on their cell phone. When the patient calls for help, the sister will say, 'Tell the patient to sleep. It's at night'."

Because of this kind of dereliction of duty displayed by the senior nurses whose responsibility it is to train the student nurses, student nurses feel that they have not been sufficiently trained. This applied especially to the method and techniques of administering medications. One student nurse noted that they were all sent out to have lunch while medications were being dispensed to the patients in some wards.

4.4.1.1 Delegation of duties

Dinnen (2009:247) postulated that assistant and other categories of nurses could be delegated to do work that was outside their scope of practice, depending on trust relationship in the profession. But delegated roles have to be communicated to others during patient care. The student nurse participants cited a number of incidences that revealed that they were not being properly delegated to perform duties according to their level of study as students. They referred to some incidents in the following words:

> "If they say 'Do this' [and] you say, 'No, I can't', they say, 'Oh you, you are in trouble', but they never teach us. They make us give bedpans, [attend to] vital signs… Those are the things they are comfortable with."
>
> "At times, some staff members send us to buy chips at the canteen, and if we refuse, they tell us that they won't teach us. They treat us like their PAs (personal assistants)".
>
> "We are told to do 'ruk and druk' (cleaning of patients and tidying of the ward), or to do [attend to] the vital data."
>
> "When staff members are handing out medication, they send the student to the other ward to ask for medication for the patients."
>
> "Delegation is done correctly, but the levels are not done appropriately; students should be delegated according to their level of training. The staff should have patience and understand them. Staff should not punish them but give them a chance to learn."

The participants stated that because they were used for trivial tasks and errands unrelated to nursing, they failed to learn essential skills such as the art of administering medications correctly.

Mellish, Brink and Paton (2000:295) assert that “a great deal of clinical instruction, formal and informal, rests in the hands of the unit professional nurse. He/she is a traditional teacher in the field. He/she must ensure quality patient care through teaching those entrusted with patient care.”

4.4.1.2 Communication

Effective communication within a health service organisation is a critical factor in the creation of a safe environment for all involved in patient care and for an environment in which safe patient care can be assured. An ability to communicate effectively is a precondition for conveying vertical and horizontal information correctly (Searle & Pera 1995:295). According to Searle and Pera (1995:295), communication is one of the foundations of a safe environment for all and safe patient care in particular. Poor communication can lead to conflict and conflict is usually the result of poor interpersonal relationships (Mellish et al 2000:315.) One of the nurse educators noted that:

> “…it takes time for information from colleges to reach the institution, and this creates a lot of mistrust and misunderstanding”.

4.4.1.3 Facilitation

Dickson, Walker and Bourgeois (2006:417) define facilitation as the technique by which one person makes challenges easier for others to cope with the purpose of co-creating new knowledge through a process of critical reflection and dialogue between learner and facilitator. They add that facilitation is a goal-oriented and dynamic process in which the facilitator or coach works in an atmosphere of mutual respect and trust with students or learners in order to help them to achieve their goals.

The clinical facilitators in the study confirmed that the students in the study have a tendency to regard others as being less experienced than them. The nursing

clinical facilitators stated that there is a lot of competition among student nurse participants.

All the student nurse participants agreed that they received no significant accompaniment at all from their designated clinical facilitators in their colleges.

> "The only time [when] the student nurses would meet them was when the clinical tutors checked attendance registers in the wards or when students have been reported for misconduct. Our clinical tutors are old, and therefore viewed as lazy."

4.4.1.4 Mentorship

A study on the integration of theory and practice was conducted by Davhana-Maselesele (2000:126). These results indicated that the clinical accompaniment of student nurses receive was deficient because there were too few mentors and professional nurse educators, and some lacked knowledge and confidence.

> "Staff should appreciate that students are there to help. Therefore they should teach them correctly."
>
> "Unit professional nurses are also accompanists. They teach us different nursing procedures. Standardisation of procedures is done with students. Students learn a lot of other things from staff besides nursing. Some students cope but others are uninterested. When students are accompanied, they are more relaxed."

4.4.1.4.1 Teamwork

According to Searle (2000:76), modern health care is dependent on a cooperative effort in which all participants support and interact with one another. The commitment of one member of a team requires a reciprocal commitment from all the other members of the team. It is important that all members of a team should be aware of the functions that each other member of the team performs.

> "Higher authority should strengthen management in this hospital. Discipline and good professional behaviour will make staff and students work together. We need to work as a team as nurses and other staff members."

4.4.1.4.2 Roles

In each clinical environment, each individual role player has specific responsibilities and functions that he or she is expected to be able to perform effectively (Harvey et al 2002:577). According to Harvey et al (2002:577), individuals, teams and organisations all require a mastery of the skills and knowledge that are appropriate to their functions before they can apply evidence-based practice. A facilitator's role is to enable the development of reflective learning by helping learners to identify their needs. If learners have mastered the art of self-reflective practice, they will be able to learn how to guide processes, apply critical thinking and assess the achievement of their learning goals. Any "doing" role is essentially practical and task-driven in nature, and focuses on being able to perform administrative tasks correctly, to support those who need help, and to identify whatever tasks needed to be performed. This kind of "enabling" facilitation role is developmental by nature because it seeks to make learners effective in all the tasks that they need to be able to perform and to be able to identify and release the potential lead that is inherent in learners as individuals.

Ohrling and Hallberg (2002:531) identified significant differences between those preceptors who voluntarily agreed to accept their responsibilities and those who were compelled by their institutions to accept the responsibility of accompanying student nurses in their clinical settings.

Here are a few of the statements made by the participants in this study:

> "Student nurses want to retain their student status and therefore there is a lot of absenteeism. They don't want to work weekends and holidays. They take chances, check off-duties and think they will not be seen. They think they are least important. They do not work according to task delegation; they work to finish."
>
> "Matrons should discuss with students what they have learnt in the wards and ask how they are treated."

4.5 THEME 3: STUDENT NURSE ACCOMPANIMENT GUIDELINES

The South African Council (1992:7) asserts that *accompaniment* is indispensable for the success of all forms of teaching student nurses, and that all registered nurses and midwives are required for the tasks involved in the accompaniment of student nurses in clinical settings. The student nurses' reflective journals also revealed their perceived dissatisfaction with their clinical learning experiences. In these journals they indicated that neither nurse educators nor unit staff had provided adequate accompaniment for student nurses who had been placed in hospitals for the purpose of professional accompaniment and tutoring in clinical settings in the Limpopo Province (Lekhuleni et al 2004:3).

The student nurse accompaniment guidelines that were assembled for the purpose of this study were formulated from the inputs that were received from the members of all four groups of participants. The categories, clusters and sub-clusters that emerged from the data analysis are summarised in table 4.4.

Table 4.4 The categories, clusters and sub-clusters identified under the theme: *Student nurse accompaniment guidelines*

Categories	Clusters	Sub-clusters
4.5.1 Role player education	4.5.1.1 Role clarification	
4.5.2 Addressing the shortage of staff problem	4.5.1.2 Implementation of communication strategies	4.5.1.2.1 Strengthening of relationships
		4.5.1.2.2 Relationships between college and clinical area
	4.5.1.3 Additional post-filling plan	4.5.1.3.1 Other strategies on clinical accompaniment

4.5.1 The education of role players

According to Reeves, Zwarenstein, Goldman, Barr, Freeth, Hammick and Koppel (2007:1), patient care is a complex activity that requires all health care and social care professionals to work together in an effective manner. The evidence, however, suggests that these professionals did not collaborate well together. Interprofessional education (IPE) offers a possible solution to the problems of improving the quality of collaboration among health care professionals and consequently of improving the quality of care that is offered to patients. Participants raised concerns about the adequacy of the knowledge and skills of the clinical staff and the effect that this had on the achievement of the objectives of clinical accompaniment. During the focus group interviews the following issues were raised:

"Staff should be made to appreciate that student nurses are there to help. Students need to be taught correctly."

"The professional nurses must delegate students according to their level of training."

"Students should be orientated before starting to work so that they can know what to do in the wards."

4.5.2 Addressing the problem of the shortage of staff

Billings and Halstead (2005:340) have classified a variety of factors that, if implemented, will improve the quality of clinical accompaniment that is offered to student nurses. These factors include the following conditions:

- One nurse needs to be designated to instruct a specific number of student nurses.
- The best results can only be obtained from the pairing model. This requires the interaction of one patient with one student and with one registered nurse.
- Clinical teaching should be regarded as a partnership between the instructor and a student nurse. In this way, these nurses will be accorded a greater amount of human dignity and recognition than they currently seem to be receiving.
- The academic institution (the nursing college) and the hospital should agree to a joint model that will serve as a master plan for the practice of student nurse accompaniment in clinical settings.
- A greater use should be made of professional nurses who are able to serve as clinical accompanists. Such professional nurses should also be employed on a part-time basis by the academic institution at which the student nurses are registered.

This, admittedly, is an ideal long-term situation that will require greater resources than are currently available to most hospitals and most nursing colleges in the Republic of South Africa.

4.5.2.1 Role clarification

Hardyman and Hickey (2001:59) have emphasised that the role of the clinical facilitator is to improve the knowledge, practical skills and clinical competence of student nurse through a process of direct role-modelling that serves to bridge the gap between theory and practice.

In addition to this, Oliver and Aggelton (2002:30) stated that both clinical facilitators and students need to have a clear understanding of the process in which they are engaged as well as a clear idea of their roles and responsibilities.

> "The permanent staff should not punish or report students for mistakes; they should teach them and give them a chance to learn."

4.5.2.2 Implementation of communication strategies

In a study about the phenomenon of burnout among Japanese hospital nurses, Shimizu, Mizone, Kubota, Nishima and Nagata (2003:185) found that the communication skills of health care professionals and student nurses could be improved if they learned to accept "valid criticism" and were also able to learn the skills involved in "negotiation".

The student nurse participants in this study described their concerns about communication during their experiences of clinical accompaniment in the hospital in which the study was conducted. One comment made about the quality of communication prevailing in the hospital was:

> "At times we are shouted at in front of patients and we are called 'stupid'. Doctors blame nurses for what they have done themselves."

This kind of behaviour is in direct contradiction with what Shimizu et al (2003:185) suggest in the recommendations that conclude their study.

4.5.2.3 Possible strategies for increasing the number of staff needed for student nurse accompaniment in colleges

In South Africa, new strategies are needed to improve the human resources for clinical accompaniment by professional nurse educators in hospitals. Some of the recommendations made by participants in the focus group discussions included:

> "Hospital must get more staff."
>
> "The private college uses older people with experience but age limits them from accompanying students effectively. It seems they tire easily during the long days."
>
> "Other colleges should consider appointing older nurses with experience for the accompaniment of students."
>
> "Look at stronger retired nurses from 'Operation Buyelekhaya' to mentor nurses."

4.5.2.3.1 Strengthening of relationship

The participants in this study reported that poor relationships between the student nurse accompanists and the permanent staff in the respective wards were often the cause of stress. In a factor analysis that was performed by

Timmings and Kaliszer (2002:203) during the course of research the following five factors were identified as the causes of the greatest amount of stress:

- the difficulties student nurses had in meeting the goals set by the academic requirements of their courses
- the dysfunctional dynamics that characterised the relationships between the professional nurse teachers and the permanent staff in the ward
- the inadequacy of the clinical experience that the student nurses were receiving
- the finance constraints that affected all aspects of the hospital's operations
- the stress induced by the death of patients (Timmings & Kaliszer 2002:203)

> "Patients are 'nicer' when they know that you are students. They appreciate and respect us."
>
> "They call you 'nurse', say 'Thank you' when you help them; they call us 'sister', 'matrons'. They make us feel like future matrons."

4.5.2.3.2 Relationships between the nursing college and what happens in clinical accompaniment areas

Mellish et al (2000:295) point out that the professional nurse in charge of a ward should be "fully aware of the practical progress of each student allocated to her unit [so that they] can ask her (if [she is sufficiently] competent) to demonstrate the technique to others."

Many of the student nurse participants in the focus group discussions were not, according to the participants, sufficiently involved in the clinical procedures that took place in the hospital. Here is one comment that is representative of what many of the other respondents thought:

> "You cannot use what you learnt at school. Staff wants you to do vital data and not higher-level duties. Recording is done by staff without doing the procedure. You are told you are wasting time when doing things correctly."

According to the student nurse participants, their experiences of clinical accompaniment was characterised by an insufficient number of opportunities for practice and for the learning and mastery of essential procedures.

> "It becomes difficult when doing OSCE-practical exams now that students are not allocated to casualty. Procedures are not done in full."

4.5.2.3.3 Other strategies for clinical accompaniment

Parker, Webb and D'Souza (2005:112) have noted that learning from experience encourages student nurses to reflect upon their personal experience as a means of discovering solutions to problems by making use of their past experiences. Carlson et al (2003:30) support this observation, and add that "clinical environment offers the student an opportunity to learn and develop critical competencies in the nursing profession".

"Staff need to help where students need help."

"Orientate students on starting to work in the ward."

"Accompaniment should be reasonable. Tutors need to be enabled to accompany all students. Colleges [need] to review the number of clinical tutors [who are] allocated to a public hospital."

"We are aware of the shortage of clinical facilitators. We also know that there is shortage of registered nurses in the hospital. Colleges and hospitals should access more registered nurses through the system of appointment of retired nurses [such as in] 'Operation Buyelekhaya'."

"The clinical facilitators from colleges should have hospital/clinical experience."

"The colleges and hospitals should work in partnership and plan together to make student clinical accompaniment a success."

4.6 CONCLUSION

Chapter 4 presented an analysis of the data in terms of the categories, themes and sub-themes that the researcher identified in her analysis and classification of the recurrent themes that were embedded in the data. The researcher also supported the conclusions reached in this chapter by quoting findings from the literature review that confirmed the importance of categories, themes and sub-themes that she identified in this study.

Chapter 5 sets out the conclusions, limitations and recommendations of the study.

CHAPTER 5

Conclusions, limitations and recommendations

"Learning is not attained by chance; it must be sought for with ardour and attended to with diligence."

Abigail Adams

5.1 INTRODUCTION

Chapter 4 discussed the data analysis. This chapter presents a summary of the research findings. It also takes note of the limitations of the study, and make recommendations that pertain to the findings of this research.

5.2 AIMS OF THE STUDY

The aims of this study were:

- to discuss and analyse the socially constructed nature of reality as it pertains to the truth of human knowledge and opionions
- to emphasise the relationship between the researcher and the objectives of study
- to emphasise the value-laden nature of any enquiry of this nature, and of this one in particular

5.3 THE OBJECTIVES OF THE STUDY

The objectives of this study were as follows:

Phase 1: Step 1 – To investigate the views and opinions that the student nurses in the study entertained about their experiences of clinical accompaniment in the hospital environment

Phase 1: Step 2 – To obtain the views and opinions of the clinical accompanists about the student nurses and their experiences during their experiences of clinical accompaniment in the hospital environment

Phase 2: Step 1 – To explore what might be done to improve and make more effective and meaningful the experiences of the student nurses during their clinical accompaniment in the hospital environment

Phase 2: Step 2 – To explore what could be done by the clinical accompanists to improve and make more effective and meaningful the experiences of the student nurses during their clinical accompaniment in the hospital environment

Phase 3: Step 1 – To identify, explore and describe the ways in which the student nurses experienced clinical accompanists during their periods of clinical accompaniment in a hospital environment

Phase 3: Step 2 – To make recommendations that could be used to develop a tool that would be able to assist clinical accompaniments during their clinical accompaniment of the student nurses who are assigned to their care in the hospital environment

5.4 THE RESEARCH QUESTIONS

For the purpose of this study, the researcher formulated a number of research questions and divided them into the following three groups or phases:

Phase 1: Step 1 – What were the views and opinions of the student nurses about their own experiences during their periods of clinical accompaniment in the hospital environment?

Phase 1: Step 2 – What were the views and opinions of the clinical accompanists about the experiences, attitudes and behaviour of the student nurses during their periods of clinical accompaniment in the hospital environment?

Phase 2: Step 1 - What could be done to improve the experiences of the student nurses during their periods of clinical accompaniment in the hospital environment?

Phase 2: Step 2 - What could be done to improve the views of the clinical accompanists with regard to their experiences of the student nurses during their compulsory periods of clinical accompaniment in the hospital environment?

Phase 3: Step 1 – How did the student nurse experience the attitudes and actions of the clinical accompanists during their periods of clinical accompaniment in the hospital?

Phase 3: Step 2 – What recommendations can be made towards the development of a tool that could act as a guide for clinical accompaniments as the accompany student nurses during a compulsory periods of clinical accompaniment in the hospital environment?

5.5 RESEARCH DESIGN AND METHODOLOGY

The researcher adopted and utilised a qualitative research design in the construction and accomplishment of this study because she believed that a qualitative research method would be the most effective for achieving her goals.

5.6 SAMPLE AND SAMPLING

The researcher used a non-probability sampling technique. She therefore invited participants whom she thought were most representative and characteristic of the typical elements of the whole population that were available for scrutiny. As a result of this approach, she assembled three groups of student nurses and one group of clinical accompanists to participate in the focus group interviews and discussions. These focus group discussions were the source of the empirical data. The data were categorised and reduced by the researcher into a number of discrete themes and sub-themes. This allowed her researcher to make meaningful assertions and draw conclusions from a mass of data that she had obtained from the focus group discussions and interviews.

5.7 FINDINGS

The purpose of the study was to gain an in-depth understanding of the experiences of a purposive sample of student nurses during their periods of clinical accompaniment in a public hospital in the Gauteng Province of the Republic of South Africa. In order to perform a data analysis, the researcher divided the study into the following three themes or categories, which she later divided into sub-themes in order to provide an even clearer understanding of the themes possible.

In order to place herself in a position to draw valid conclusions from the data, the researcher based the focus group discussions on the following three main themes:

- **Theme 1: The clinical environment**
- **Theme 2: Learning opportunities for student nurses**
- **Theme 3: Student nurse accompaniment guidelines**

5.7.1 Theme 1: The clinical environment

The student nurse participants were exposed to teaching, instruction and guidance from the permanent registered nurses at the hospital. Some experienced emotional stress in these situations because of the attitudes and behaviour of some registered nurses at the hospital. Because of these registered nurses' behaviours and attitudes, the student nurses sometimes felt uncomfortable, angry, dispirited and discouraged. All these experiences were discussed in detail in chapter 4 of this dissertation. While all the matrons were described as "nice" by student nurse participants, the matrons themselves apparently did not engage in any form of intervention between the student nurses and their clinical accompaniments.

It was the opinion of all the student nurse participants that most clinical facilitators were not performing their duties as clinical instructors coaches, teachers, mentors and role models – which were their expected roles and

functions. Most of these student nurses did not value the quality of their clinical instructors – experiencing the facilitator to be “lazy and old”.

5.7.2 Theme 2: Learning opportunities for student nurses

Most of the participants agreed that they did not get opportunities for clinical practice that were essential to acquire the knowledge and experience expected from qualified nursing practitioners. They mentioned that they were not allocated for a sufficient length of time to areas such as the casualty department. They also pointed out that they were used for menial tasks such as attending to the routine needs of the patients and tidying up wards. While they were not averse to performing these tasks, such activities contributed nothing to the expansion and refinement of their abilities to undertake more important clinical tasks and procedures. To master these skills the student nurses needed the personal and direct guidance of the registered professional nurses who were in charge of the hospital wards. They also noted that they were tolerated in wards provided that there were no emergency or difficult cases to handle. At such times they were often sent out of the ward to undertake trivial tasks that contributed nothing to the refinement of their knowledge and skills. They lacked training in the correct ways in which to administer medications and to perform other procedures that are essential for all nurses registered in terms of the SANC regulations).

Student nurses agreed that they were motivated by the understanding and friendliness they received from their patients. Some patients expressed their appreciation for whatever the student nurses did and encouraged them to continue in the pursuit of their future careers. The student nurses enjoyed working directly with their patients because it was the patients (and clinical accompanists) who gave student nurses respect and who were grateful for the way in which the student nurses attended to the patients’ needs.

During discussions on a topic of this sub-theme all student nurses felt respected and appreciated. This was one aspect of their clinical accompaniment experience that brought them happiness and fulfilment.

5.7.3 Theme 3: Student nurse accompaniment guidelines

All four focus groups provided inputs about elements that might contribute to a tool that would be useful to clinical accompanists of student nurses. The main ideas focused on the formulation of guidelines that emphasising the education and training required by all responsible for achieving the objectives of clinical accompaniment. Other suggestions were designed to improve relationships between individuals and between the nursing colleges and the various hospital departments to which the student nurses were assigned. Other suggestions would improve the quality and effectiveness of communication between the hospital authorities and the student nurses assigned for clinical accompaniment and to address the shortage of teaching staff in the clinical areas – without which the effective clinical accompaniment of student nurses becomes impossible.

5.7.4 Recommendations for guidelines that would help to improve the processes involved in the clinical accompaniment of student nurses in the hospital

The following recommendations emanated from the participants in all the focus group discussions:

- The hospital needed to appoint additional staff in order to improve the quality of patient care.

- The roles of the student nurses and the reasons for which the SANC required them to be placed in hospitals for clinical accompaniment need to be defined by the SANC so that the permanent staff of the hospital would know why these students were being placed in clinical settings.

- There was an urgent need for improving the quality of the relationships between the various groups of individuals who needed to participate in the clinical areas, and relationships that prevailed between the nursing colleges from where the student nurses came and the individuals who were responsible for the clinical areas and the services offered by the

hospital. The nurse administrators (from the hospital) and nurse educators (from the college) need to enhance these relationships.

- All role players involved in the clinical accompaniment of student nurses in clinical settings need to be aware of the need and importance of making clinical accompaniment more effective in the hospital. The regulations issued by the SANC specify that annual periods of clinical accompaniment in authorised hospitals are an essential core component of each individual nurse's training who desires to be registered by the SANC. Because of this, the clinical account of each student nurse is important and should not be undermined by inadequate procedures, a lack of understanding and an absence of interest, responsibility and concern by those involved with clinical accompaniment.

- It is the responsibility of those who occupy positions of authority in the nursing establishment to take practical steps to ensure that all student nurses who are assigned to periods of clinical accompaniment in authorised hospitals should receive all forms of training and instruction that are appropriate to their level of training.

5.8 LIMITATIONS OF THE STUDY

The study is limited by the fact that all of the participants were drawn from only one of the colleges that sent student nurses for accompaniment to one hospital. This was inevitable because during the period in which this study was undertaken, all the students from the other colleges were either on leave or were working in clinics. It would have been possible to base this study on a much wider range of views if the student sample had included students enrolled at all designated colleges.

5.9 RECOMMENDATIONS FOR FUTURE RESEARCH

The scope of this study was limited to a particular hospital in one of the nursing colleges in the Gauteng Province of the Republic of South Africa. Thus the views obtained from both the student nurses and the clinical accompanists,

reflect only the views and experiences of a group of respondents in a small area of the country. The researcher therefore recommends that further research be conducted in the other provinces of the Republic of South Africa, where differences in culture, experiences, traditions and attitudes might influence the results.

It would be useful for future researchers to focus on how clinical accompanists experience the behaviours, attitudes and opinions of the student nurses assigned to them for clinical accompaniment. The main focus of this study has been on the behaviour, feelings, attitudes and opinions of the student nurses themselves. It would be valuable for the purpose of obtaining a more complete and nuanced understanding of these phenomena by conducting additional research into the experience of the clinical accompanists.

5.10 CONCLUSION

This chapter focused on the final conclusions that the researcher reached in the study, and the recommendations that she made for possible future research into the themes and issues that have been raised by this study. The inherent limitations and recommendations for future research have also been articulated as part of the overall design of the study.

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ANNEXURE A

PERMISSION LETTER TO CONDUCT RESEARCH FROM GAUTENG DEPARTMENT OF HEALTH

ANNEXURE B

SAMPLE OF PERMISSION GRANTED FROM:

1. MILLITARY HEALTH TRAINING FORMATIONNURSING COLLEGE

2. LILLIAN SPENGANE MEMORIAL NURSING SCHOOL

ANNEXURE C

REQUEST TO LILLIAN SPENGANE MEMORIAL NURSING SCHOOL FOR PERMISSION TO CONDUCT A RESEARCH

ANNEXURE D

LETTER TO PARTICIPANTS

CONSENT LETTER FOR PARTICIPANTS
University of South Africa
Faculty of Human and Social Sciences
Department of Health Studies

Dear Sir /Madam

REQUEST FOR CONSENT TO PARTICIPATE IN RESEARCH STUDY

I am an MA (Public Health) student at the University of South Africa, presently engaged in a research project entitled: "STUDENT NURSE EXPERIENCE OF CLINICAL ACCOMPANIMENT IN A PUBLIC HOSPITAL IN GAUTENG PROVINCE", under the supervision of Professor SP Hattingh of the Department of Health Studies.

The objective of this study is to explore and describe the experiences of student nurses placed by nursing colleges at a public hospital for clinical experience with accompaniment of tutors or trained nurses.

To complete this study I need to conduct interviews with groups of students for about 60 minutes or more. The interviews will be audio taped for verification by an independent expert in qualitative research. In this study I undertake to safeguard your anonymity by omitting the use of names and places. Confidentiality will be assured by the erasure of taped material on completion of the transcripts of these tapes. The transcribed material will only be shared by myself, my supervisor and the independent expert in qualitative research. You are hereby giving your informed consent to these proceedings reserve the right to cancel it at any stage of the proceedings. It is understood that you are under no obligation to participate in this study.

The direct benefit to you for participating in this study is that you will have the opportunity to verbalise your experience during clinical accompaniment while place by the college in a public hospital.

A summary of the research findings will be made available to you on request. Should you wish to contact the researcher, you may do so at the following address:

Ms NS Mntambo
55 Prinsep Avenue
Dunnottar
Cell : 079 881 7929

Thanking you

_____ _____
PARTICIPANT (SIGNATURE) DATE

_____
NS MNTAMBO : RESEARCHER

_____
SP HATTINGH : SUPERVISOR

Department of Health
Lefapha la Maphelo
Department van Gesondheid
Umnyango wezeMpilo
EKURHULENI HEALTH DISTRICT
Private Bag X1005, Germiston, 1400
Enquiries: Modise Makhudu
Tel: (011) 876-1817
Fax: (011) 876-1818
Email : ModiseMa@gpg.gov.za
DaleenD2@gpg.gov.za

To: Ms. N. S. Mntambo – Far East Rand Hospital

From: Mr. M. Makhudu – Director for Ekurhuleni Health District

CC: Mr. M. Mosenogi – Acting CD for Ekurhuleni and Sedibeng Health Region

Ref: DIR/583/3/2007

Date: 12th of January 2007

RESEARCH PROJECT : "STUDENT NURSE EXPERIENCE OF CLINICAL ACCOMPANIMENT IN A PUBLIC IN GAUTENG PROVINCE"

1. Please refer to the above mentioned request dated the 23rd of March 2007.
2. Hereby approval is given to perform your research at Far East Rand Hospital.
3. Kindly share your findings with this office.

Regards

MODISE MAKHUDU
DIRECTOR FOR EKURHULENI HEALTH DISTRICT
DATE: 29/3/2007

Lillian Spengane Memorial Nursing School
Plot 37
Cloverdene Road
Van Ryn Small Holdings
Benoni
Tel : (011) 969-5539
23 July 2008

Dear Ms. N. S. Mntambo

RESEARCH PROJECT : "STUDENT NURSE EXPERIENCE OF CLINICAL ACCOMPANIMENT IN A PUBLIC IN GAUTENG PROVINCE"

1. Please refer to the above mentioned request dated the 02 July 2008
2. Hereby approval is given to perform your research at utilizing students from Lillian Spengane Memorial Nursing School.
3. Kindly share your findings with this office.

We wish you well in your studies.

Regards

.....
Mrs. N. Ngubeni
Principal
Date:

Telephone: 012-674-6267
Facsimile: 012-674-6347

Military Health Training Formation
Nursing College
Private Bag X 1022
Thaba Tshwane
0143

NURSING COLLEGE

"Scientia Praestemus-Excellence through Knowledge"

From:	To:
Sender: S.A.M.H.S Nursing College	**Organisation:** Far East Rand Hosp
Date, time sent: 28 March 2007	**Attention:** Ms N.S Mntambo
Tel / Fax: (012) 674- 6267	**Fax No:** (011) 813 1411
Number of pages (including cover page):	

This fax may be confidential and/or privileged. If you are not the intended recipient, you should not copy it nor use it for any purposes, nor disclose its contents to any other person. Please notify the sender immediately if you have received this fax in error.

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☐ For Review ☐ Please Comment ☐ Please reply ☐ Please recycle

"The SANDF / SAMHS is committed to HIV prevention."

RESTRICTED

South African Military Health Service
Nursing College

SAMHS Nursing College
Private Bag X1022
Thaba Tshwane
0143
29 March 2007

Department of Health
Far East Rand Hospital
Private Bag X 50
Springs, Gauteng

AUTHORITY TO INCLUDE STUDENT NURSES IN A RESEARCH PROJECT

1. Authority is hereby granted to include SAMHS Nursing College student nurses in a research project to be conducted at Far East Rand Hospital while they are at this clinical area.

2. Thank you.

(J.F.M. MABONA)
OFFICER COMMANDING SAMHS NURSING COLLEGE: COL

APPENDIX C

Tel: 012 429 6543
Fax : 012 429 6688

University of South Africa
Department of Health Studies
P O Box 392
UNISA
0003
02 July 2008

Lillian Spengane Memorial Nursing School
Plot 37
Cloverdene Road
Van Ryn Small Holdings
Benoni

Dear Sir/Madam

REQUEST TO PARTICIPATE IN RESEARCH STUDY

I am an MA (Public Health) student at the University of South Africa; presently I am engaged in a research project entitled:

"STUDENT NURSES' EXPERIENCES OF CLINICAL ACCOMPANIMENT IN A PUBLIC HOSPITAL IN THE GAUTENG PROVINCE."

My supervisor and promoter is Professor S. Hattingh in the Department of Health Studies.

The objective of the study is to explore and describe the experiences of student nurses who are allocated in a public hospital and to formulate guidelines for the public health officials to support the training of student nurses in a public hospital during clinical accompaniment.

In order to complete this study I need to conduct group interviews on student nurses who have been placed by the nursing college at the hospital for clinical accompaniment for at least one year since last year. In this study I undertake to safeguard the identity of the school, students, any individuals and hospital by omitting use of names and places. Confidentiality will be assured by erasure of taped material on completion of transcripts and editing of the tapes. An independent expert on qualitative research, my supervisor and me will be the only people who will share the transcribed material. All participants reserve the right to withdraw from the study at any stage without any obligation. The interview will be recorded for 45 to 60 minutes or more and notes will be taken by the researcher as well.

The direct benefit to the participations in this study is that they will have the opportunity to verbalize their views on student nurses' experiences during clinical accompaniment in a public hospital in the

Gauteng Province. For the nursing school, the study will assist strengthening of clinical guidelines for student nurses accompaniment during experiential training at the hospital.

A summary of the research findings will be availed to the school on request. Should you wish to contact the researcher, you may do so at the following address:

Ms N S Mntambo
55 Prinsep Avenue
Dunnottar
Cell . 079 881 7929

Thanking you

N S Mntambo (Researcher)

05 May 2008

Date

Telephone: 012-674-6267
Facsimile: 012-674-6347

Military Health Training Formation
Nursing College
Private Bag X 1022
Thaba Tshwane
0143

NURSING COLLEGE

"Scientia Praestemus-Excellence through Knowledge"

From:	To:
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Message

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"The SANDF / SAMHS is committed to HIV prevention."

RESTRICTED

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2. Thank you.

(J.F.M. MABONA)
OFFICER COMMANDING SAMHS NURSING COLLEGE: COL

RESTRICTED
"World -class Clinical Service"

Department of Health
Lefapha la Maphelo
Department van Gesondheid
Umnyango wezeMpilo
EKURHULENI HEALTH DISTRICT
Private Bag X1005, Germiston, 1400
Enquiries: Modise Makhudu
Tel: (011) 876-1817
Fax: (011) 876-1818
Email : ModiseMa@g[illegible]g.gov.za
DaleenD2@g[illegible]g.gov.za

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DIRECTOR FOR EKURHULENI HEALTH DISTRICT
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