

**STUDENT NURSES' EXPERIENCES OF THEIR CLINICAL
ACCOMPANIMENT**

by

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November 2011

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DECLARATION

I declare that **STUDENT NURSES' EXPERIENCES OF THEIR CLINICAL ACCOMPANIMENT** is my own work and that all the sources used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any institution.



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25 November 2011

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STUDENT NURSES' EXPERIENCES OF THEIR CLINICAL ACCOMPANIMENT

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ABSTRACT

An exploratory, descriptive qualitative design was used to describe and explore how the students experienced their clinical accompaniment in a specific programme.

The researcher conducted a tape recorded interview to a 14 individual students, who voluntarily agreed to participate in the study, transcription followed, then data analysis was done following the steps as described by De Vos, Srydom, Fouché and Delport (2005:334) citing Creswell (1998:142) where open coding leads to themes and subthemes.

From the findings of this study it was discovered that the students experienced dissatisfaction in terms of their development of clinical skills to competence as they were not given an opportunity due to negative circumstances around their training. Recommendations were made to improve clinical accompaniment of student nurses for all involved so that the student nurses acquire clinical skills, knowledge and values.

Key terms

Accompaniment; bridging course for enrolled nurses; clinical field; clinical skills; clinical teaching.

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List of abbreviations

CEFs	Clinical Education Facilitators
SANC	South African Nursing Council
UNISA	University of South Africa

List of annexures

- Annexure A Letter requesting permission to conduct the study
- Annexure B Letter obtaining permission to conduct the study
- Annexure C Consent from student participants
- Annexure D Interview protocol
- Annexure E Example of a portion of transcribed data

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Nursing education has a responsibility to ensure that nurses on training acquire clinical skills in order to render quality nursing care. It is for this reason that accompaniment, as an integral part of clinical teaching, be conducted to ensure integration of theory with practice, and the integrity of clinical services provided to patients/clients, as well as development of competency in student nurses. The mastery of the clinical skills learnt ensures nursing care of a high standard and the nurses are also capacitated to provide quality nursing care at preventive, promotion-enabling, rehabilitative, maintenance or terminal levels (Mellish, Brink & Paton, 2000:212).

The South African Nursing Council (SANC), which is a statutory body responsible for regulation of training of nurses in South Africa, defines accompaniment as the “conscious and purposeful guidance and support for the student, based on her unique needs, by creating learning opportunities that make it possible for her to grow from passiveness to involvement, to independent, critical practice (Regulation R.683 of 1989, as amended) (SANC, 2006). The process of accompaniment takes place in conjunction with direct involvement and physical presence of a tutor, and the registered nurse in the clinical settings/wards together with the guidelines and learning aids. Mentors and preceptors can also be used to maximise accompaniment for students and, as such, promote acquisition of clinical skills (Quinn, 2000:245; Mellish et al., 2000:217).

Accompaniment is therefore a form of clinical teaching that is planned and programmed to guide and support students. It is during the accompaniment that students get an opportunity to learn to make decisions and judgment in the health practice, develop creative thinking, critical judgment, interpersonal, communication skills and psychomotor skills. Appropriate attitudes, accountability and responsibility for own actions will also be learnt (Mellish et al., 2000:217). The registered nurse and the unit manager, as personnel

in charge of the wards, are in a better position to assist students with practice as they are constantly with students during placement. As such, opportunities for students to learn in practice are created. These learning experiences will facilitate the achievement of learning outcomes (SANC, 1997:5).

Despite the measures put in place for effective clinical teaching and learning, however, an outcry from clinical practice for lack of competency on the nurses' part cannot be ignored. Clinical teaching and learning, as an integral part of nursing education, appears to be problematic. Gaps in knowledge, skills, attitudes and values of nurse practitioners have resulted in recommendations for the extension of practice through compulsory internships (Arries & Du Plessis, 2004:12).

This study sought to explore and describe the experiences of bridging course student nurses on clinical accompaniment in the Limpopo Province, South Africa.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

1.2.1 Source of the research problem

The students registered for *Bridging Course for Enrolled Nurses* leading to registration as a general nurse at a Limpopo Nursing School are placed for clinical instruction at the selected hospital and clinics within the district. The placement of these students is done following the SANC guidelines (Regulation R.683 of 1989, as amended) (SANC, 2006). The clinical instruction received by students also include accompaniment, which is considered an integral dimension of clinical teaching. In Limpopo Province, this cadre of nurses are given study leave to proceed to train as registered nurses after years of being employed as enrolled nurses. As a result, they are assumed to be clinically competent.

Mabuda (2008:3) cites Massarweh (1994) as saying that clinical teaching provides opportunities for students to correlate theory with practice. The unit manager and the registered nurses in the unit have the responsibility to ensure that patients receive best health care, and, if there are students, the students must be taught the appropriate nursing care skills. Mellish et al. (2000:209) state the responsibility of the registered nurse as "enabling a student who has been assigned to her unit for experience in that specific area

of nursing, to encounter and cope with such situations, which will facilitate her growth and development into a competent independent practitioner". The involvement of the registered nurse is very crucial for the support of the student.

The SANC guidelines also stipulate the direct and physical involvement of the nurse educator/tutor in accompaniment (Regulation R.683 of 1989, as amended) (SANC, 2006). The content for all nursing science subjects must be correlated into practice in the real life situation during accompaniment. It is thus important that the role of the nurse educator must extend from the classroom to the clinical area as well. The support and guidance of the unit manager, registered nurses as well as the nurse educator cannot be overemphasised in the accompaniment of student nurses.

1.2.2 Background to the research problem

Nursing as a profession deals with people whose lives are vulnerable due to ill health. Patients' lives can only be saved if nurses are competent enough to deal with their conditions. Students need to be accompanied so that they can observe demonstrations of proper nursing care, then thereafter practice the skills under direct supervision of the professional nurse, until the student is competent. Direct supervision ensures that the student is practically prepared as a nurse during training, so that even after completion, the student remains a competent nurse practitioner ready to serve humanity.

In spite of guidelines provided for the training of students, gaps confront the students and render them not proficient in their carrying out of their nursing care. According to Carlsons, Kotze and Van Rooyen (2003:30), students' experiences during accompaniment reflect uncertainties due to lack of opportunities for support and guidance to acquire clinical skills. The contributing factors were as follows:

- Unavailability and inaccessibility of staff due to time constraints
- Shortage of equipments to execute nursing care
- Lack of support and guidance in the clinical learning environment by nursing personnel
- There is also a role ambiguity of nurse educators, in the sense that they have the theory teaching role, clinical teaching role and administration

The study by Mabuda (2008:4) cites Lita, Alberts, Van Dyk and Small (2000) as having indicated that workload and shortage of personnel affected opportunities for teaching and guiding student nurses placed in the wards. Quinn (2000:187) cites Fish and Pur (1991) that supervisors were found to be having enormous workloads, with their roles not well defined. Mabuda (2008:4) cites Moeti, Van Niekerk and Van Velden (2000) in their study that revealed shortage of staff, equipments and supplies as affecting the competency of newly-qualified registered nurses. The study was conducted in the North West Province, South Africa. Similar findings were reported in the study conducted by Waterson, Harms, Quipe, Maritz, Manning, Makobe and Chabeli (2006:57) (citing Morolong & Chabeli, 2005). The study indicated that newly-qualified registered nurses were observed to be not competent in applying clinical knowledge and skills to practise.

A study by Brooks and Moriarty (2006:42) conducted in United Kingdom, revealed that students complained of placements that were not addressing their learning needs, as practicing registered nurses complained of overwhelming numbers of students, with the result that accompaniment difficulties were experienced. Positive relationships between students and clinical teaching facilitators promote learning. A study by Hayden-Miles (2002:421) revealed fear of ridicule by nurse educator as negatively affecting their competence. Hayden-Miles (2002:421) cites Robinson (1991) as indicating that clinical instructors must build a positive relationship with students, therefore establishing a caring environment whereby constructive criticism and values can be expressed without destroying the student's self image.

In the same breath, the study by Casssimjee and Bhengu (2006:48) revealed that poor relationship between the students and supervisors resulted in insufficient supervision and lack of feedback, and thus affecting competency to be acquired by the students.

The researcher, as a nurse educator, also noted that the clinical accompaniment of students, despite the guidelines provided for each unit, is not up to standard as expected.

1.3 RESEARCH PROBLEM

The researcher noted with concern that students are neglected in the clinical setting and are not supervised as expected but their clinical records reflected that they were supervised. Some students reported that they are being harassed when they practise the nursing care procedures correctly, because doing the procedure correctly is assumed to be time consuming and delaying the routine. Delegated duties are not the actual duties expected according to their learning needs that are to be covered in that unit. At times, they are left on their own in the units, with no registered nurse to supervise or consult; the problem stated as shortage of professional nurses. This contravenes the student contract which state that they should at all times practice under direct or indirect supervision of a registered nurse.

It is on this background and observation that the researcher sought to explore and describe the experiences of student nurses with regard to their accompaniment in the clinical health practice.

1.4 RESEARCH PURPOSE AND AIM

The purpose of this research is to explore and describe the experiences of bridging course students of accompaniment in the clinical practice. The aim being to make recommendations for improvement.

1.5 RESEARCH OBJECTIVES

To meet the purpose of the study, the following objectives were formulated:

- To explore and describe experiences of bridging course students on accompaniment in clinical practice
- To make recommendations that would facilitate accompaniment of students in the clinical practice

1.6 RESEARCH QUESTIONS

The participants were asked questions, where in answering they were expected to describe their experiences, therefore enabled the researcher to obtain necessary data on their accompaniment. The questions were as follows:

- How did accompaniment influence your acquiring of clinical skills?
- What do you think the role of the unit manager should be in terms of accompaniment?
- What do you think the role of the nurse educator should be in terms of accompaniment?
- Is there anything that you would like to say in terms of your accompaniment experience?

1.7 SIGNIFICANCE OF THE STUDY

The research findings could assist nurse educators and unit managers to realise their important roles in guiding and supporting the students towards clinical proficiency. The study could also assist unit managers and nurse educators to maximise learning opportunities for accompaniment. Implementation of effective plans could provide support and guidance for students.

The SANC Regulation R.683 of 1989, as amended, stresses that the practice instruction be applied in such a manner that the subject content for integrated nursing science be presented with accompaniment. Therefore, the nurse educators and unit managers, after having understood the lived experiences of the students, could maximise learning opportunities for accompaniment (SANC, 2006).

1.8 ASSUMPTIONS UNDERLYING THE STUDY

According to Botes (1995:6), no study is value-free and for this reason researchers must make their assumptions explicit. Assumptions are basic principles that are accepted as true on the basis of logic or reasoning without proof or verification (Polit & Hungler, 2003:528). In research, the assumptions are embedded in the philosophical base of the

framework or study. These assumptions influence the development and implementation of the research process. Their recognition leads to the development of a more rigorous study (Burns & Grove, 2005:146). According to Chinn and Kramer (1999:76), assumptions are not intended to be empirically tested, but are underlying propositions, which can be challenged meta-theoretically. Researchers select certain assumptions from the paradigm perspective in response to their interaction with the research field. In this study, the researcher made meta-theoretical, theoretical and methodological assumptions.

1.8.1 Meta-theoretical assumptions

Meta-theoretical assumptions are not testable and deal with the human being and society (Botes, 1995:6). The term “meta-theory” refers to critical reflection on the nature of scientific inquiry. Meta-theoretical reflection typically addresses issues such as the nature and the structure of scientific theories, the nature of scientific growth, the meaning of truth, explanations and objectivity (Babbie & Mouton, 2007:20). Meta-theoretical assumptions are interrelated sets of concepts, beliefs, commitments and propositions that constitute the study (Henning, Van Rensburg & Smit, 2004:15). Their origin is philosophical in nature, and therefore not meant to be tested. Meta-theoretical assumptions denote commitment to the truth of the theories and laws of a particular paradigm (Mouton & Marais, 1999:19). Creswell (2003:11) postulates that qualitative research focuses on the process occurring as well as the product.

Botes (1995:17) explains that meta-theoretical assumptions serve as a framework within which theoretical statements are made. The author argues that while these assumptions are not testable, they must be reconcilable with theoretical statements. The assumptions that were made about clinical accompaniment, which is intricately linked to nursing practice, were related to the person, environment, health and nursing (Oerman, 2001:32). In this regard, it is assumed that:

Person: The bridging course nursing students are adult learners who are in the process of being registered nurses. They are self directed, in constant interaction and co-existence with their lived world in the clinical setting and their patient, who is the main concern for nursing discipline.

Environment: Clinical settings (hospital and clinics are the clinical setting (lived world)) where accompaniment is implemented to enable the bridging course student to develop clinical skills to care for patients. The learning environment selected for the students' clinical experiences is specified by the curriculum.

Health: Bridging course is a nursing discipline within the health sciences. Clinical education of bridging course students is experiential in nature. Accompaniment equips the bridging course student to render competent, compassionate care to patients.

Nursing: The caring aspect is the core of nursing. As a result of caring, the nurse moves away from his/her own viewpoint and look at things from the viewpoint of others and make the other (patient) a priority. Bridging course training equips the student to be a competent nurse practitioner who will be able to render a competent safe service to ill patients.

For the purposes of this study, assumptions are that:

- Experience is a personal knowledge gained by an encounter in practice
- Students learn from their clinical experience and must be assisted to develop the attitudes and values required
- The psychological environment is important to learning; as such students must be treated with respect and dignity, even their contributions. Such an approach will promote active participation of the students
- An environment of trust between all parties must be maintained so that students will feel at ease; each learner considered an individual

1.8.2 Definition of theoretical terms

The theoretical and operational definition of the key terms used in this study is defined as follows:

- **Accompaniment**

Accompaniment refers to conscious and purposeful guidance and support for the student as determined by the unique needs of the student (SANC guidelines for bridging course for

enrolled nurses leading to registration as a general nurse, Regulation R.683 of 1989, as amended) (SANC, 2006). Learning opportunities that promote growth from passiveness to involvement and independent critical practice are created. Accompaniment process must be facilitated through direct involvement and physical presence of a nurse educator with all the relevant teaching guidelines and learning aids (Regulation R.683 of 1989, as amended) (SANC, 2006). The unit manager is also involved, as well as other registered nurses in the unit, where the student has been placed (Mellish et al., 2000:214). In this study, the researcher refers to guidance provided to the student nurse in clinical practice.

- **Bridging course for enrolled nurses**

This is a two year diploma programmed for education and training of enrolled nurses leading to registration with the SANC as a general nurse, Regulation R.683 of 1989, as amended (SANC, 2006).

- **Clinical field**

The health service area where the health service is provided to patients, clients and families, so the health service can be promotive, preventive, rehabilitative, maintenance or terminal (Mellish et al., 2000:206). In this study, it refers to an institution in the Limpopo Province where students are allocated for clinical practice.

- **Clinical skills**

Clinical skills are techniques, methods, attitudes and behaviours necessary to execute nursing care according to the standards set by the SANC guidelines (Regulation R.683 of 1989, as amended) (SANC, 2006). This will incorporate the cognitive, affective and psychomotor skills.

- **Clinical teaching**

Clinical teaching refers to a practical instruction programme that is aimed at supporting and guiding the student towards clinical competence, thus enabling the student to apply the nursing care skills to patients, clients and families (Mellish et al., 2000:209).

- **Nurse educator**

A registered nurse and or midwife facilitating achievement of learning objectives in the classroom and clinical field (SANC, 1992:7). The nurse educator must hold an additional qualification in nursing education, and plays a role in guiding and supporting the students so that they would be able to utilise a range of intellectual, interpersonal and practical skills, to solve problems in the interest of patients and clients and provide advice on health related issues.

- **Programme objectives/outcomes**

These are desired results upon completion of each learning process of which learners have to demonstrate attainment, as such learners are to be assessed on a continuous basis (Van Der Horst & McDonald, 2003:5). Objectives, as indicated by the SANC Philosophy (SANC, 1992:7), are the critical curriculum content that need to be mastered within certain stipulated period upon which the student will be evaluated.

- **Clinical accompanist**

A registered nurse charged with an obligation to teach skills and knowledge to students who are placed under his/her supervision for practical experience. On the outset, a practitioner teaches, guides, shows and demonstrates, with the student as either a non-participant or participant observer depending on the respective stages. The student is also accompanied at a later stage where the student demonstrates and is assessed for competence or lack of competence, then feedback is given by the accompanist for correction (Mellish et al., 2000:136).

- **Registered nurse**

A person registered with the SANC in accordance with the Nursing Act, Act no 33 of 2005, can serve as a mentor, preceptor and clinical facilitator (South Africa, 2006a:5).

- **Student nurse**

A student nurse is an enrolled nurse undergoing a two year diploma programme leading to registration as a general nurse, according to the SANC Regulation R.683 of 1989, as amended (SANC, 2006). The student undergoes basic training where theoretical and practical skills at a nursing school, hospital units and clinics are acquired.

- **Unit manager**

A unit manager in this study refers to a registered nurse in charge of a hospital unit or clinic.

1.9 RESEARCH DESIGN AND METHOD

Once the researcher had made her theoretical assumptions it was necessary to make methodological assumptions. Methodological assumptions explain the methods and specific ways that the researcher uses to understand the phenomenon. Research methodology refers to a scientific method that includes steps, procedures and strategies for obtaining and analysing data. It also provides answers to questions, and guidelines of dealing with difficulties arising during the research process that incorporates all procedures that scientists have used, and currently using, and could use in the future to search for knowledge (Burns & Grove, 2005:23). The research methodology chosen is qualitative. This methodology refers to an inquiry into phenomena using an in depth and holistic manner that aims at collecting rich narrative materials in order to interpret meanings behind the narratives (Polit & Beck, 2004:729).

1.9.1 Research design

The research design is the overall plan (Polit & Beck, 2004:49). The design is the descriptive qualitative study that does not have a particular disciplinary or methodological root. It can also be referred as a naturalistic inquiry or content analysis (Polit & Beck, 2004:263). This design is also exploratory and descriptive research design (Polit & Beck, 2004:341).

1.9.2 Population

Students training for Bridging Course in their final year at a Nursing School in Limpopo Province, South Africa (Regulation R.683 of 1989, as amended) were targeted to participate in this study (SANC, 2006).

1.9.3 Sample and sampling techniques

A purposive, networking and random sampling of 14 students pursuing *Bridging Course for Enrolled Nurses*. Second year students were targeted as their experience as students would yield rich data needed for the study. Networking sampling facilitated in finding more participants that are interested to can participate in the study (Burns & Grove, 2005:352). Males and females were equally invited. The researcher recruited those interested to participate in the study.

1.9.4 Data collection

Data collection is a process whereby information pertaining to a phenomenon is sourced through instruments such as interview schedules and guides, questionnaires, records, artefacts, observations and field notes. The method and instruments for data collection are determined by the research design and research approach, which can either be qualitative or quantitative or both. For this study, data were collected by use of semi-structured interviews supplemented by field notes. There were twelve questions to describe their accompaniment experiences. The English language was the preferred medium of communication, but if students preferred to talk in any language, they were allowed to do so. Translation was done verbatim. An audiotape was used to capture the words as said by the participants to refrain from pausing and asking respondents to repeat statements already stated. Field notes enabled the researcher to reflect on observations on the field (Polit & Beck, 2004:235).

1.9.5 Data analysis

Data analysis was conducted by using editing analysis style, and open-coding system in accordance with the steps as described by Tesch (Creswell, 2003:155). The researcher

read through the data and searched for meaningful segments and units. Categorisation scheme to sort and organise data follows once segments have been identified and reviewed. Patterns and structure are searched to connect thematic categories (Polit & Beck, 2004:571). Data was analysed and explored systematically to generate meaning from existing recorded data.

1.9.6 Trustworthiness

The researcher used strategies for trustworthiness as indicated by De Vos, Strydom, Fouché and Delport (2005:345) (citing Lincoln & Guba, 1985) to ensure trustworthiness of the research data. The strategies are credibility, dependability, conformability and transferability. These strategies are discussed in detail in chapter 3.

1.9.7 Ethical considerations

The permission to conduct the study was requested from the management of the institution. The name of the institution is not reflected in the study. Permission from the participants was sought, and their consent was also obtained. Participants were ensured that participation is voluntary. The names of the students are not being reflected in the study for confidentiality. It will read: Participants were ensured that their names will not be reflected in the study. The participants could withdraw from the study any time if they wish to. Fair treatment was maintained as well as privacy. The background of the study, purpose, objectives, methodology, ethical considerations and reporting systems were explained. Participants were also be given information leaflet to explain the rules. The following are the rules that were discussed with the participants:

- To close their cell phones during the session to prevent distraction
- To be free to ask the researcher to repeat the question if not heard, or to clarify the question if not understood
- The researcher asked the participants to attend to the call of nature before the onset of the session for smooth running of the session
- The researcher pleaded with the participants to be honest enough and give true information

The participants could ask questions if they need to be clarified about any aspect of the study (Stommel & Willis, 2004:289).

1.10 SCOPE OF THE STUDY

The study covered students pursuing *Bridging Course for Enrolled Nurses* that are in their final year. Only one Nursing School was used for this study. Interested students were recruited to participate in the research. There was no age, sex, social class or religion restriction.

1.11 STRUCTURE OF THE DISSERTATION

Chapter 1: Orientation to the study

Chapter 2: Literature review

Chapter 3: Research design and methodology

Chapter 4: Analysis, presentation and description of research findings

Chapter 5: Conclusion and recommendations

1.12 CONCLUSION

For acquisition of clinical skills, the learning environment must be equipped with material resources and qualified personnel as facilitators to teach and supervise the students during accompaniment, to ensure that they become proficient, and ultimately meet the outcomes and objectives as stipulated by the regulations of the statutory body, the SANC. From the research undertaken by other researchers, indications are that there are still problems as far as accompaniment is concerned, hence the gaps in clinical skills required in the practice of nursing as reflected in the studies.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is defined by Burns and Grove (2005:93) as “an organised written presentation of what has been published on a topic by scholars”. The literature review is searched in terms of what scholars have previously discovered. De Vos et al. (2005:263) cite Mouton (2001:87) as describing literature review as a review in terms of available body of knowledge, whereby the researcher observes the extent at which previous scholars did research on the topic of interest. When the researcher has the body of knowledge, then a summary and evaluation of information are done so as to indicate an understanding of the given body of knowledge (Stommel & Willis, 2004:339).

According to Polit and Beck (2006:331), literature review provides the researcher with a background for understanding current knowledge on a topic and illuminates the significance of a new study. Thus, it serves an integrative function, which facilitates the accumulation of evidence on a problem. The steps involved in literature review include, searching, reading and writing. The researcher describes the studies of other scholars, then critically analyses literature projected, synthesises and evaluates the literature based on the current study (Burns & Grove, 2005:93).

Furthermore literature review formulates a foundation of knowledge on which to base the findings of the study (Lobiando-Wood & Harber, 2007:790). The researcher reviews literature to discover what is known about the topic (Stommel & Willis, 2004:339). From any given context, a description of a current knowledge can create an opportunity to debate and secure generally accepted facts and statements if they do give a true picture, and detailed discussions given from literature studies, the researcher can identify gaps in what is known and indicates any statements with gap in knowledge as data could not be found during that period of researching, and this knowledge gap will persuade the current researcher to search for data.

The content of this chapter is organised in the framework of Rogers, developed from his humanistic theory (Quinn, 2001:53). The theory indicates the psychological environment as very crucial for learning to take place. The psychological environment includes orienting students about what is expected from them; accepting contributions of students with respect; and developing a relationship of trust and respect between learners and all involved in facilitation of learning. According to Quinn (2001:55), as citing Rogers (1961), creation of a safe psychological environment would make students feel at ease, promote discussion of feelings and values.

Discussions and involvement of students promote and develop in the students a sense of personal value and worth. The nurse educator becomes a facilitator or helper; not a conveyor of information. The student must be an active participant and engage in self evaluation rather than waiting to be followed. Neumann (1997:322) emphasises that scientific conduct should be upheld whereby the researcher shall not falsify or distort the information from literature or plagiarise the work of others.

Presentation for the content is under the headings of accompaniment, approaches of accompaniment, clinical learning environment, role players in accompaniment, qualities for effective accompaniment and research on accompaniment.

The sources for this literature review consist of theoretical and empirical research literature. The body of knowledge from theoretical literature was obtained from monographs requested from library. Empirical literature was obtained from the:

- Periodicals, sources like, *Curationis* of the Democratic Nurses Organisation of South Africa (Denosa) (a body to which the present researcher is a subscriber)
- The Internet; Monographs (in the form of books); Unpublished research articles; and Published research articles (Burns & Grove, 2005:94)

2.2 ACCOMPANIMENT

Accompaniment is a noun, its verb accompany, according to the *Reader's Digest Complete Word Finder* (1993), to accompany means to attend, escort, guide, conduct, go with or support. From this context, accompaniment refers to giving an individual or

individuals relevant attention, escorting people accordingly, taken along or conducted for the purpose of support and guidance (Mellish et al., 2000:213; Muller, 2006:288).

The SANC Regulation R.683 of 1989, as amended (SANC, 2006) explains accompaniment as:

[A]conscious and purposeful guidance and support for the student, based on her unique needs, by creating learning opportunities that make it possible for her to grow from passive to involvement, independent, critical practice. This process of accompaniment takes place in conjunction with direct involvement and physical presence of a tutor, supplemented by the availability of guidelines and learning aids”.

The philosophy and policy of the SANC points at accompaniment as a directed assistance and support by a registered nurse or midwife, aiming at developing a student to be a competent practitioner making use of appropriate guidelines and teaching aids (SANC, 1992:8). Therefore, accompaniment means facilitating, guiding and the support the student receives, bearing in mind the learning needs, outcomes and assessment methods that the accompanist and the student must discuss.

Quinn (2001:396) explains accompaniment as a tutoring whereby a relationship between the student and a tutor is established, and is characterised by formal teaching, assessment and support for the student progressively throughout training. In the clinical practice, tutoring is referred to a mentor. The role of the tutor in accompaniment is as follows:

- Encouraging and support
- Liaising and representing
- Monitoring
- Coaching
- Negotiating
- Counselling

Bulman and Schultz (2004:79) clarify the role of a mentor as that of a supporter, a source of emotional encouragement, and therefore stimulate self confidence in reflective practice for appropriate decision-making in the clinical practice. The purpose of accompaniment of

the learner is to facilitate learning and development of clinical skills that bring about a change in the behaviour of the learner. Although this is possible, accompaniment has to be managed in a manner that will facilitate this learning (Meyer, Naudé & Niekerk, 2004:85).

Accompaniment also includes assessing the learner in various ways through using different assessment techniques to measure competency or outcomes. Jacobs, Vakalisa and Gawe (2004:75) indicate that assessment should be a daily bread whenever there is facilitation of learning, according to outcomes based education. Assessment must emerge as a transparent, and continuous in the learning situation. Gravett and Geyser (2004:93) indicate that assessment practices must include diagnostic assessment, which determines prerequisite knowledge of the learner; formative assessment, which supports the process of learning; and summative assessment, which takes place at the end of the programme to determine whether the learner is competent or not.

As implied by these definitions and explanations of accompaniment, the student is accompanied to the patient or client to observe or practise clinical skills under the supervision of a registered nurse, which could be a nurse educator, a unit manager, a preceptor or mentor, for the sake of assisting the student to acquire clinical skills. The student actively participates in learning and, as such, would ultimately gain necessary knowledge, values, attitudes and mastery of clinical skills. Planning is mandatory in the form of programmes together with the student.

2.2.1 Approaches to accompaniment

Accompaniment opens an opportunity for learning, if facilitators efficiently engage in planning. Theories can help guide the process of accompaniment. There are theories for adult learning that can be used, for example, the humanistic basis of adult learning, the andragogical teaching and training of adults and the experiential learning approach. Of the theories identified, the theory of choice is the humanistic basis of adult learning, by Carl R Rogers (Quinn, 2001:51).

The other approaches for accompaniment that can be used can be lecturer practitioner's role, mentorship and preceptorship. These approaches will endeavour to assist the student to achieve learning objectives and acquire necessary knowledge, skills and attitudes.

2.2.1.1 Theories/Model of accompaniment

Barbie (2007:10) defines a theory as a "systematic explanation for the observations that relate to a particular aspect of life". Stommel and Willis (2004:4) describe a theory as an organised symbolic representation of reality, and as such a theory specifies relationship amongst ideas or phenomena of interest.

The purpose of a theory when conducting a research is the fact that it guides the research process; and provides a basis for describing, explaining or predicting outcomes. In case of a qualitative design a theory will guide, describe and explain rather than predicts, as the researcher must exercise bracketing during the research process (Polit & Beck, 2004:253). Streubert-Speziale and Carpenter (2003:47) indicate use of a theory as that of describing, explaining, predicting or controlling a phenomenon. In terms of qualitative research, a theory is developed after data collection, whereas in quantitative design the research is undertaken to test a theory (Burns & Grove, 2005:24).

2.2.1.2 The humanistic basis of adult learning theory

Humanistic theory holds a view that affective components of human beings must be considered, rather than the behaviour as observed from behavioural theorists. In contrast to cognitive theorists that study a human being from his/her thinking capabilities, humanistic theorists consider affective perspective as well. Quinn (2001:51) indicates that the affective components constitute the most important aspects of life, as it includes aspects like feelings, attitudes and values. Humanistic theory supports the phenomenological philosophy as indicated by Quinn (2001:51) that, "reality lies in a person's perception of an event and not in the event itself".

Hamachek (1978), as cited by Quinn (2001:51), defines the humanistic viewpoint as:

[A] psychological stance that focuses not so much on a person's biological drives, but on their goals; not so much on stimuli impinging on them, but on their desires to be or to do something; not so much on their past

experiences, but on their current circumstances; not so much on life conditions per se, but on the subjective qualities of human experiences.

Humanistic theory promotes human growth, as such enhances individual fulfilment and self actualisation. The key tenets of humanism are; self direction, empowerment and learner autonomy. The overall understanding of these tenets implies that adults are autonomous in their learning if allowed to, and if autonomy is to be established the powers must be shared (Quinn, 2001:52). Carl R Rogers' approach in humanistic psychology is the theory of choice and it will be outlined below. This theory will be used to plan for accompaniment in the clinical health practice. Students require empowerment if they are to accomplish clinical skills. This theory will serve as guide in assisting students to achieve their learning outcomes (Quinn, 2001:52).

Humanistic Psychology: Carl R Rogers

Rogers holds the stance that learning must be student centred. In his ten principles of learning, he strongly upholds relevance of learning, student participation and involvement, self evaluation and a conflict-free atmosphere in the classroom. The teacher plays a role of a facilitator, a link that provides resources for learning and a responsibility to share feelings and knowledge (Quinn, 2001:53). The principles that underpin this belief are the following:

- Human beings have the potential to learn. All students that pursue nursing as a profession possess a natural potential to learn, provided they are given an opportunity to learn.
- The more the subject matter is perceived by students as relevant, the more significant learning will take place. This is true, as learners will not focus on issues that are not related to their studies.
- Students tend to resist learning that threatens a change in self organisation. Many students will terminate their education and training in institutions that lost touch in the reputations of students as individuals.
- External threats to the individual should be minimal for learning to take place. It is true that threats induce anxiety; and anxiety reduces intellectual capacity. The learning environment therefore should be free from threats, but be conducive to learning, if learning has to take place.

- When the threats are low to the self, experience is observed, though in a differentiated manner, but learning will take place.
- Practical work or activities promote more learning. The importance cannot be emphasised; as learners explore with their own hands the practicalities.
- It is the responsibility of the student to participate actively for learning to take place. Where people are responsible enough of their learning, that trend will facilitate learning.
- When the student initiates learning, whereby the learner concentrates with the whole person, feelings and intellect will be more lasting. Learners that want to be followed up for learning will not perform better than those that initiate learning by themselves.
- The student is responsible for self evaluation and criticism, and that would be possible if the student maintains independence, creativity and self reliance. The student must be actively involved to attain set objectives or outcomes.
- The student must subject the self to the process of learning in the sense that continuing openness and experience shall bring about change to the learner to the learner. This trend is socially helpful in this contemporary world.

(Quinn, 2001:54)

Rogers emphasises an establishment of a relationship between the learner and the facilitator, which would be based on genuineness, trust and acceptance and empathic understanding. The student should be accepted as a human being in her own right and, as such, must be treated with respect and dignity (Quinn, 2001:54). Empathic understanding implies that facilitators feel for the students and try to see issues from students' perspective. It is therefore a fact that facilitators should establish relationship with the student that would academically support and appreciate the student towards a better performance.

Implications for teaching and learning

The natural potential for learning must be stimulated by giving students projects that would stimulate curiosity and present problems and challenges. In the clinical units, patients come with health problems that need solutions, students can be challenged to solve such problems, with the guidance of the nurse educator and registered nurses supervising

patient care. According to Rogers, the psychological environment is important to learning; as such, facilitators of learning must not treat the student with ridicule and impatience. Students must be treated with respect and dignity, even their contributions. Such an approach will promote active participation of the students (Quinn, 2001:55)

An environment of trust between all parties must be maintained so that students will feel at ease; each learner must be considered an individual and, as such, the use of forenames must be promoted. The use of forenames may enhance feelings of identity.

Involvement in decision making is considered important as it promotes a sense of personal value and worth. As such, where possible, student representatives can be allowed to contribute ideas and suggestions. Quinn (2001:55) indicates that the role of the facilitator according to the humanistic approach becomes that of a helper, facilitator and another learning source, “rather than a conveyor of information”.

The active involvement of the student will be encouraged by involving students in facilitation strategies like projects, practical work and field based studies. Students should also be encouraged to engage in self-assessment of their learning so as to create self monitoring for competence and responsibility. To help students in taking responsibility for their own learning, learning contracts must be used, with the facilitator assisting the student to achieve the learning outcomes.

The learning contracts

The purpose of learning contracts is to provide learning needs of the students to the student and relevant role players. They serve as means of addressing promotion and maintenance of professional competence for the nurse. Competence in this regard will be decided upon by educators, professional nurses in the units and nursing service management (Quinn, 2001:59).

The following are steps of the learning contract:

Step 1: Diagnosis of learning needs

Students identify their current state of knowledge and skills in comparison to the learning outcomes in the clinical practice, and state how such learning outcomes will be achieved. The students will need the guidance of the nurse educators. That will mean the students will be provided with learning outcomes for each unit where placement is done (Quinn, 2001:59).

Step 2: Specifying learning objectives

The learning needs identified are written as objectives for acquisition of certain knowledge and skills (Quinn, 2001:59).

Step 3: Specifying learning resources and objectives

Students focus on how each learning objective will be achieved, and planning is needed. In case of nursing, the students will receive orientation in the health units, receive facilitation of learning through demonstrations for nursing care, and consult clinical manuals, other literature and facilitators (Quinn, 2001:60).

Step 4: Specifying evidence of accomplishment

According to Quinn (2001:60) for every learning objective, the student must describe the evidence of having achieved that objective. For example, a written case study, a written nursing process for a patient or a supervised clinical procedure undersigned by a registered nurse.

Step 5: Specifying how the evidence can be validated

The criteria for which the evidence will be judged are decided upon. In terms of accompaniment, the criteria are assessment tools for evaluating care given. For example, assessment tool for the procedure, nursing process, case studies health education and

unit management. The nurse educator will validate the evidence provided (Quinn 2001:60).

Step 6: Reviewing the contract with the consultants

The student reviews the contract with the nurse educators, supervisors and colleagues once complete to ensure clarity and appropriateness of the contract (Quinn 2001:60).

Step 7: Carrying out the contract

The contract is then implemented and any necessary adaptations will be made along the process of learning (Quinn, 2001:60).

Step 8: Evaluating the learning

The nurse educator judges the evidence produced (Quinn, 2001:60). These learning contracts are concerned with diagnostic and formative assessments, as such help the student to identify weaknesses and strengths, then redirect the learner for best performance through giving of feedback that consists of qualitative advice (Gravette & Geysler, 2004:94).

2.2.1.3 Other approaches to accompaniment

For students to achieve learning objectives, facilitators should be put into place to assist the students. Approaches that may result in significant help are the lecturer- practitioner, the link teacher, the mentor, the preceptor and coaching defined thus:

The lecturer practitioner

This must be a qualified registered nurse with a additional qualification in nursing education qualification. The practitioner must be clinically competent; her responsibility shall include facilitation of learning, supervision and assessment of students (Quinn, 2001:428).

The link teacher

According to Quinn (2001:428), the link teacher liaises between the unit managers and students, and therefore develops qualified staff and help in problem-solving and maintenance of a positive learning environment for students. Qualified staff can include the supervisors/unit managers, mentors and preceptors.

The mentor

A mentor is a qualified and experienced in the clinical health practice who formally provide educational and personal support to a student during her placement in that particular unit. The support according to Quinn (2001:427) includes, “teaching, supervision, guidance, counselling, assessment and evaluation”. Given the varied aspects of support, the student will benefit tremendously. Olivier (2002:102) explains the role of a facilitator as “a mentoring guide to progress; and demonstrate complex activities”. That mentoring guide directs the learners to gain the necessary skills. Mentoring ensures empowering of an individual in the workplace, thus making the most of human potential by enabling the mentee to discover and use own talents and encouraging, nurturing the unique contributions and helping them to be competent in their own right (Morton, Cooper & Palmer, 2000:39).

The preceptor

Quinn (2001:427) defines a preceptor as “an experienced nurse, midwife or health visitor within a practice placement who acts as a role model and resource for a student who is attached to him or her for a specific time span or experience”. The preceptor possesses a certain qualification, and the student’s role is to observe the interactions and decisions made. During meetings conducted by the preceptor, the student can ask the reasons behind actions and decisions made. The attachment of the student to the preceptor can take a day or a week, depending on the learning needs of the student.

Coaching

Coaching implies offering additional support to the student who needs that assistance. It is a person to person process whereby the student is assisted to improve his or her performance. A five stage model is used with the acronym 'C.O.A.C.H' to best empower the student:

- Circumstance* – the coach and the student attempt to get an overall picture of the current problem.
- Objective* – the coach helps the student to formulate objectives that he/she aims to achieve.
- Alternatives* – various options and alternatives are discussed.
- Choice* – the two stakeholders reach a decision on the best feasible alternative for the student after having exhausted all the factors.
- Handover* – the two parties decide on how the choice will be implemented and the type of support needed for the choice.

(Quinn, 2001: 434)

Wilson (2007:21) indicates the principles of coaching as follows:

- Waiting for our turn to speak
- Giving our own experience
- Giving advice
- Listening and asking for more
- Intuitive listening

It is thus important that nurse educators employ these principles to effectively support the students, so as to ensure that they acquire necessary knowledge, skills and values.

2.3 GOALS OF ACCOMPANIMENT

Accompaniment is aimed at assisting the student to gain competency based practice on clinical skills when caring for patients, clients, families or groups of people in the clinical health practice, be it the wards, outpatients clinics, casualty unit, operating theatre, health

centre or community clinic. The student is said to be competent if he/she applies the necessary knowledge, skills and attitudes when executing his/her nursing duties (Mellish et al., 2000:208).

The student is afforded an opportunity to be guided towards professionalism, thus enabling the nurse to practise duties accountably and responsibly within set standards.

For bridging course students (Regulation R.683 of 1989, as amended) (SANC, 2006), accompaniment will assist them to acquire knowledge, skills and attitudes and, as such, become competent in the following aspects:

- Skills in deciding on independent judgements in terms of patients/clients needs when executing nursing care
- Displaying interpersonal skills when dealing with patients, relatives and members of the health team
- Demonstrate communication skills when talking to patients/clients and members of the health team
- Demonstrate teaching capability as he/she will be expected to teach the future generation of nurses
- The ability and insight to manage the unit, material and personnel allocated to his/her unit
- The ability to internalise professional ethics, standards and professional conduct and apply these in his/her daily practice
- Display competency in applying technical skills, observational skills and critical judgement based on knowledge and practice
- Display responsibility and accountability to patients/clients, colleagues, the employer as an authority, the public and to herself for acts or omissions
- The ability to use the nursing process when assessing the needs of patients, developing nursing care plan and evaluating the effectiveness of the plans made (Mellish et al., 2000:213)

2.4 CLINICAL LEARNING ENVIRONMENT

The consideration of the clinical environment is important to maximise learning opportunity for students. According to Andrews and Andrews (2006:870), placements education models are crucial, and they must have the following key aspects:

- Joint guidance and shared commitment between education and service personnel.
- Practice learning environment that promote high quality care, positive role models, evidence based practice and multi professional focus.
- Student support base that upholds self directed learning, guides the student by identifying learning needs, creating learning opportunities and supervising the students; with roles and responsibilities of lecturers and service practitioners clearly defined.
- Use of assessment methods for practice that have innovative approaches jointly developed by the educational and service colleagues, for example, key players like ward managers, mentors, link lecturers and placement coordinators.

All key players must have clear roles and responsibilities defined at both academic and service settings, with provision of formalised system of communication and feedback. Because clinical placements schemes must reflect best practice best models must be formulated to clarify communications between role players.

Quality assurance system must be put in place, in the form of feedback and audit across settings, as a mechanism to facilitate provision of constructive feedback and evaluation of students. Andrew and Andrews (2006:871) cite Löfmark and Wikblad (2004) who indicate that feedback and opportunities to reflect on practice facilitate and increase the students' self confidence. Students must play a role in giving feedback with regard to the overall learning environment, so that both the academic and the service staff can determine quality placement settings and maximise student learning.

Figure 1.1 indicates the best model that best shows collaboration between the academic personnel and service personnel. The student enjoys frequent communication between the link tutor, the mentor and the unit staff. Thus clinical environment in this context is conducive to learning.

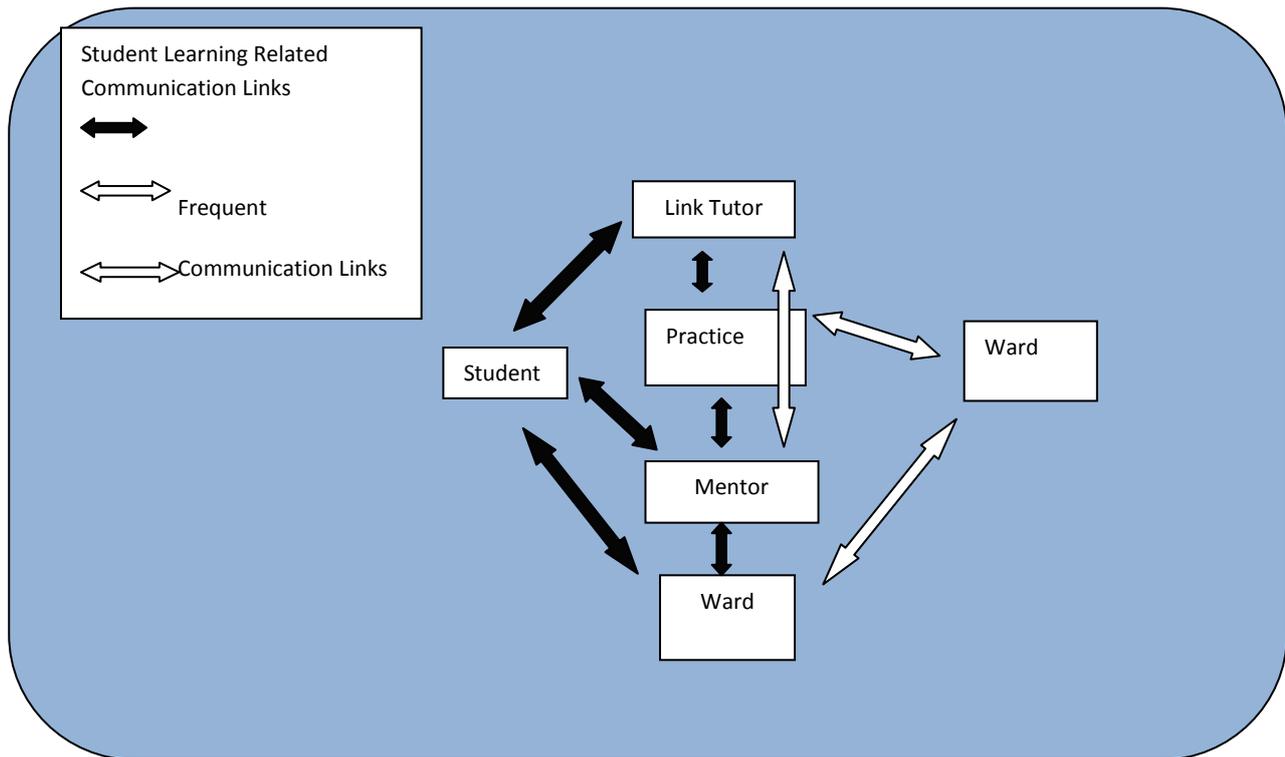


Figure 1.1 The Andrews and Andrews (2006) clinical placement education model of recommended ‘best practice’

Cassimjee and Bhengu (2006:48), in their study, cited Chabeli (1999:25) and Lambert and Glacken (2005:664) as saying that within the clinical environment the clinical instructor must have confidence in the abilities of the students, a role model, knowledgeable and experienced. The clinical instructor must be aware of students’ individual needs, and becomes a resource person for the students. Such an instructor would concentrate at clinical education and do justice to the patients. Dickson, Walker and Bourgeois (2006:420), in their study, indicated the following aspects in terms of creation of clinical learning environment:

- Clinical facilitators must know their own limitations in the practice, then find a more appropriate professional nurse in the clinical practice to demonstrate nursing care procedures for the students, so as to promote a collaborative clinical environment.
- The notion of stepping in to help a student who grasps slowly, then stepping back to give control of the experience of the student, so that the student can develop confidence in his/her practice. By so doing, a student is supported when it is needed, and independence when the student needs that.

- Developing alliances in the clinical area to create a positive morale that would render the clinical environment conducive to learning.
- Promotion of interaction among clients, students and the staff, where there is sharing of information with the students, promotes self-worth of the students, and involving the patient reinforces holistic caring.
- Use of clinical buddies, whereby a student is budded with a registered nurse that would enhance learning opportunities for the time the student has been placed. Given the fact that the student spends much time with the registered nurse, this strategy would benefit the students.

The above-mentioned aspects would really promote a positive clinical learning environment for the students, if taken into consideration, because it establishes a conducive environment for learning.

2.5 ROLE PLAYERS IN ACCOMPANIMENT

Student training requires a team that will accompany the student during her training in acquiring the necessary competencies and skills and this are regarded as accompanist or role players in the accompaniment of student nurses.

2.5.1 The nursing education manager

The manager must develop a clinical placement for students for the entire period of training according to the requirements of the SANC, with learning outcomes and stipulated hours (Regulation R.683 of 1989, as amended) (SANC, 2006). Clinical manuals must be made available for use by facilitators of learning (nurse educators and service practitioners) and students, as well as assessment instruments for facilitators, and students must be orientated to the instruments so that they can know what is expected of them during assessment. Clinical meetings must be in place to ensure that whatever problems that might occur concerning practical learning of students are addressed. The manager must make it a point that there are necessary equipments to implement nursing care, through liaison with the nursing service manager.

Develop policies with regard to training and they are communicated to the students, including accompaniment as well. Continuous development for nurse educators is crucial to ensure that there is up to standard knowledge, skills and attitudes that would be necessary for teaching students. The recruitment of nurse educators is important to ensure that there will be enough nurse educators to accompany students. It is important that the students and nurse educators' ratio are conducive to facilitation to learning, as large numbers can have a negative impact on facilitation, and as such disadvantage the student (Mellish et al., 2000:291).

2.5.2 The unit manager

The unit manager serves as a supervisor for the unit. Falender and Shafraske (2004:3) describe supervision as a professional activity involving training and education that is aimed at developing a student into a science informed practitioner. The processes involved are observation, evaluation, feedback, the facilitation of the supervisee assessment, and the acquisition of knowledge and skills by instruction, modelling and mutual problem solving. The processes must be taken in such a manner that ethical standards, legal prescriptions and professional practices are considered to protect the patient/client.

The unit manager must orientate students to their new placement, plan a teaching programme, based on learning outcomes, involve all students allocated to the unit, and supervise that students are in the unit according to duty schedule. The clinical environment must be conducive enough to deliver quality nursing care, promote competency, provide an opportunity for facilitation of learning provide space and equipment (Quinn, 2001:425). Quality assurance mechanisms must ensure that the staff undergoes a continuous development to ensure clinical competence. The ability to insist on absolute safety of the patient, safety, dignity, comfort and privacy, as such a sense of responsibility is instilled into them.

Learners will need delegation according to their learning outcomes, the supervision done during execution of nursing care, and finally feedback given (Gravette & Geysler, 2004:94). Assessment must be fair, valid, transparent and practicable. The assessment process must be reliable, assessment workload realistic and should cover a wide range of

approaches and methods. The necessary recordkeeping must be compiled as evidence of the student having been accompanied. The ability to motivate learners by showing interest in the progress shown by the student, as that appreciation will motivate students to work much better (Mellish et al., 2000:164).

2.5.3 The professional nurse

The professional nurse as a functional nurse under the supervision of the unit manager must play the following role:

- A skilled practitioner of nursing to be able to facilitate learning.
- An up to date knowledge is imperative to teach and apply basic nursing care to patients/clients.
- She should maintain high professional standards honesty, integrity, objectivity and upholds the norms and values of this profession, and as such serve as a role model for students (Mellish et al., 2000:211).
- The imparting of knowledge and skills should be in a clear, understandable manner to ensure that learning takes place.
- Implements teaching programmes developed by the unit manager.
- Ensures the safety of patients during learning of nursing skills by the students by supervising students, thus ensuring that the nursing procedures are performed correctly.
- Furnish all necessary reports pertaining to evidence of accompaniment, as well as progress made by the student in the unit of placement.
- A diversity of accompaniment strategies can be made to assist students gain competency; that may range from demonstration, the teachable moment, drawing of nursing care plans, case studies, problem-solving scenarios and peer group teaching (Mellish et al., 2000:215).
- Assessment based on the performance of the student must be fair, consistent, valid and transparent. The assessment process must be reliable and the workload must be realistic (Gravette & Geyser, 2004:94). Assessment should also provide feedback to the learner for support.

2.5.4 The patient/client

The patient, as a human being whose rights and dignity must be respected at all times, need to be asked for consent whenever he/she is going to be used for teaching. An explanation of what is going to be done and why it is done needs to be done, as the patient is not an object but has a right to give consent or to refuse. An appropriate patient must be chosen so that the student can benefit from the learning experience. It is important that a suitable time be planned for the patient/client to prevent any inconvenience. The privacy and confidentiality of the patient/client must be maintained at all times (Mellish et al., 2000:156).

2.5.5 The nurse educator

The nurse educator plays an important role in the accompaniment and the development of the student. The nurse educator ensures that theory is correlated into practice. It is through the attitude portrayed by the nurse educator that the student can said to have developed the professionalism that gives the positive image of nursing (Mellish et al., 2000:213). To maintain clinical competence, the nurse educator must keep abreast of developments and, as such, will be a continuous learner (Mellish et al., 2000:72).

Relationship with the students

Mellish et al. (2000:72) cite Knox and Mogan (1987) that research undertaken in terms of student-nurse educator relationship indicated that positive relationship lead to successful learning. That positive relationship with students indicate the nurse educator's commitment to caring.

A caring relationship is displayed by the following:

- An approachable nurse educator, always ready to offer help
- A deep respect and support observed in the way the nurse educator would listen attentively to them

- The awareness of the nurse educator of the student as a unique being with physical, psychological, social and spiritual needs, as such accepts students with their differences
- The nurse educator display empathic understanding as such attempts to view situations from the student's point of view
- A caring relationship also entails that the nurse educator when responding to students' feelings also communicates that understanding (Mellish et al., 2000:73)
- Learners to be included in the programme

2.6 RESEARCH ON ACCOMPANIMENT

Previous research on accompaniment was consulted to determine the extent of the problem, and any successes experienced that the studies helped to uncover. Earnshaw (1995:274) study on mentoring; focused on experiences of the students. According to students mentoring was important in the early stages of training, where students would be socialised into the norms of the nursing profession and orientated into ward routines.

Furthermore, it is unfortunate that the role of a mentor was not clearly defined as it overlapped with that of a preceptor. In the same manner, the study by Watson (1999:261) where mentoring was used for accompaniment of students, findings revealed that the role of mentors could not be clearly identified, and mentors also did not get support from colleagues and management. The students did not benefit from mentorship as it was inconsistent and the mentors did not explicitly know their roles as mentors, and even the qualified staff experienced role conflict in terms of mentoring. Recommendations were made to the effect that mentors be trained, roles and responsibilities be clarified and the institutional support be clarified.

From this study, it can be seen that even though accompaniment through mentoring was considered of importance, but there were a lot of discrepancies that needed to be looked into, for an example, the roles of mentors, management and colleagues in the clinical area. Similarly, Moriarty and Brooks (2006:42) discovered that placements for students were not addressing their learning needs. Mentors also complained of overwhelming numbers of students, with the result that accompaniment difficulties were experienced. This study was conducted in United Kingdom. This study like the study conducted by Watson also

indicates the lack of support of management. That means mentoring as an approach for of accompaniment still there were problems involved.

For some clinical teaching institutions, research undertaken revealed that mentoring posed to be a complex challenge even though was considered to be an effective strategy in assisting students in the nursing profession (Lee, Theoharis, Fitzpatrick, Kim, Liss, Nix-Williams, Griswold & Walter-Thomas, 2006:233). That is why this study sought to assist mentors early in the career on how best they can increase their satisfaction and self confidence, in mentoring.

On the contrary, some institutions were successful with mentoring as a clinical support base for students. A pilot study conducted on a group of students indicated that mentoring made a valuable contribution as far as support is concerned for the students (Saarikoski, 2003:1014). In the same vein, Kilcullen (2007:95) investigated on the perceptions of student nurses regarding the impact of mentorship on clinical teaching. The findings revealed that mentors played an important role in promoting learning through support, role modelling, socialising students in the profession and acting as assessors.

Gilmour, Kopelkin and Douche (2007:36) researched on a different version of mentoring where senior students were mentoring junior students, and with mentoring by professional nurses as well; this is a different version as frequently mentoring by professionals is preferred. The findings indicated that though they benefited but mentoring requires ongoing commitment, face to face meetings and discussions. Mentoring was considered a faster and smooth transition from student nurses to competent professional nurses, and strategies were put in place, then the effect investigated (Nelson, Godfrey & Purdy, 2004:551). The findings revealed positive results as a decrease in turnover of mentor participants was marked and the mentorship program could recruit and retain the brightest students. There were other impediments for effective accompaniment. Research by Mabuda (2008:4) cites Lita, Alberts, Van Dyk and Small (2000:30), and Moeti, Van Niekerk and Van Velden (2004:72) as indicating workload and shortage of personnel that impeded accompaniment opportunities and indicating shortage of equipment and supplies which negatively affected the competency of newly qualified registered nurses. Quinn (2000:187) cites Fish and Pur (1991) indicated in their study that supervisors were found to be having enormous workloads, with their roles not clearly defined.

These studies raised concerns related to lack of material resources and shortage of staff as a stumbling block for accompaniment, though this shortage was not clearly indicated whether it was from resources for the functional skill laboratory or the wards; and it was not also explicitly indicated whether the shortage of staff was from the educators or the clinical staff.

In the same manner, research conducted by Carlson et al. (2003:30) on students' experiences reflected uncertainties due to lack of opportunities for them to acquire nursing skills. The contributing factors were identified as:

- Unavailability and inaccessibility of staff due to time and workload constraints
- Shortage of equipment to execute nursing care
- Lack of support and guidance in the clinical learning environment by those entrusted with a responsibility of supervision

The students experienced a number of problems that impacted negatively on their rights for accompaniment. Problems ranged from lack of material resources to negative attitude of the unit managers as far as accompaniment is concerned. This discovery revealed that training of students was not budgeted for, and management was not committed to facilitate in solving the problems, so lack of accompaniment remains a problem.

The study by, Lekhuleni, Van der Wal and Ehlers (2004:15) also indicated problems experienced by students in terms of accompaniment. There was role confusion in terms of accompaniment for students, as most nurse educators do not perceive accompaniment as their role, instead they indicated that the unit managers and registered nurses should accompany students as they are in the clinical field. The professional nurses also indicate that their role is that of patient/client care, not teaching. Now, for as long as there is this confusion students will experience competency gap as they will not get support necessary to acquire clinical skills. Cassimjee and Bhengu (2006:47) also indicated that nurse educators spend much time in theory than clinical work, and cite McCabe (1985:256) indicating role confusion in terms of clinical instruction amongst tutors, clinical instructors and students.

The repercussions of poor accompaniment were reflected on competency gap. A study undertaken indicated that newly qualified registered nurses were observed not to be competent in applying clinical skills and knowledge to practice. The study implicated problems related to shortage of staff and equipments, though it is not very clear as to the category of staff that the institutions were running short of. Similarly another research also discovered the problem whereby newly qualified nurses who were still not yet competent. Coaching was identified as a strategy to close the gaps in lack of competency. A model developed by nursing leadership used preceptors to establish coaches; that would identify areas where the new nurses need assistance for professional competence. The model remarkably assisted the newly qualified nurses to acquire the necessary knowledge, clinical skills and values and as such ensured a quality care, which were not covered during training. Another new approach saw a research based on the teaching model for nursing practice was conducted to understand the perspectives of students in terms of clinical supervision in the preceptor or the cluster model. A research was undertaken in order to help in the process of developing the competency profile of students, as newly qualified nurses were observed to be having competency gap. The students opted for the cluster model where the clinical teacher works with a group in the ratio of 1:8 or less; students enjoyed greater opportunities of learning and also supported each other this study. This study is the only one that embarked on the teaching model for the nursing practice.(Waterson, Harms, Quipe, Maritz, Manning, Makobe & Chabeli, 2006:57; Nelson, Apenhorst, Carter, Mahlum & Schneider, 2004:32; Maginnis & Croxon, 2007:218)

Positive relationships between students and clinical teaching facilitators promote learning. The study by Hayden-Miles (2002:421) revealed fear of ridicule by students as negatively affecting their competence, due to negative clinical instructor relationship. Hayden-Miles (2002:421) cites Robinson (1991) as indicating that clinical instructors must build a positive relationship with students, thus establishing a caring environment whereby criticism and values can be expressed without destroying the student's self image. In the same breath the study by Cassimjee and Bhengu (2006:48) discovered that poor students-supervisor relationships, insufficient supervision and lack of feedback were key obstructers in promoting clinical competency by students. A study by Valiant and Neville (2006:23) revealed that positive relationships promote learning as the students depend on day to day facilitation of learning by the clinicians. Yonge, Myrick and Haase (2002:84) discovered the experiences of students to the preceptorship were stress laden and frustrating. That is

why it was recommended that close communication between faculty and preceptors must prevail, and quick responses to factors that would serve as stressors must be done to prevent the potential of having student burnout. It is important that positive relationships be maintained to promote an atmosphere conducive to learning.

Research by Tsele and Muller (2000:23) revealed both negative and positive experiences by students where the quality of clinical accompaniment was looked into as well as the empowerment of organisations, clinical accompanists and clinicians. The study by Uys and Meyer (2005:28) revealed that methods of accompaniment to promote critical thinking and facilitation were not correctly interpreted, and therefore were not implemented correctly; consequently requirements of outcomes. So, much still need to be researched in terms of accompaniment. The study did not explicitly indicate the manner in which critical thinking and facilitation were incorrectly implemented.

The study by Bedward and Daniels (2005:53) raised the problem of clinical isolation of supervisors, supervisees and teachers. The clinical isolation referred to these qualified nurses not able to address issues like workloads, routines and some range of issues. These professionals felt unsupported; and not able to discuss clinical issues and as such lacked support in their daily work activities. Through meetings and consequent problem solving strategies to consolidate efforts for clinical supervision were made, and the nurses received support in terms of in service education to maintain clinical competence. What is remarkable about this study is the fact that, though it was aimed at embarking on prevention of clinical isolation of teachers, supervisors and supervisees, it improved the clinical teaching-learning environment in the sense that the students benefited from positive changes made.

Clinical nursing education was a concern and even apprehension throughout the United States. The study by Jacobson and Grindel (2006:109) pointed out the following problems:

- Lack of integration between didactic and clinical components of the curriculum.
- Inadequate preparation of preceptors for supervising and teaching students.
- Outdated clinical skills by facilitators.

The findings from this study revealed problems that needed intervention to ensure competent nurse practitioner at the end of the programmes. Differently, in Ireland a Clinical Placement Coordinator was appointed to provide support to student nurses in their various clinical placements. This was a new approach to accompaniment. Drennan (2002:475) researched into this approach to inquire into its credibility. The students appreciated the role that the clinical placement coordinators were playing, as they indicated that they were able to cope with the challenges of the clinical health practice with the help of them. The new role was perceived as more clearer as time advanced than the role of the clinical tutor, as the clinical placement coordinator played a role of supporting the students; even the clinical staff was supported to ensure a user friendly environment for both the students and the clinical staff. That was a very good approach that was comprehensive as it promotes competency to all the clinical staff.

A new approach was taken, observed in the study undertaken where factors influencing theoretical knowledge and practical skill acquisition, indicated a practical gap experienced by nurse educators in terms of clinical competence in comparison with nurse specialists in different clinical fields (Corlet & Palfreyman, 2003:188). That is why it was recommended that the nurse specialists be included in the curriculum for practical support of students. This is a new approach that suggested the inclusion of nurse specialists to promote acquisition of clinical skills by learners.

A study by Lambert and Glacken (2005:358) on the use of Clinical Education Facilitators (CEFs) indicated that students welcomed the new idea as it supported their learning tremendously. The CEFs gave support by doing the following:

- Assigning link nurses
- Maximising learning opportunities
- Facilitating the achievement of learning objectives
- Preparing the environment for learning

What is interesting about this study is the fact that the duties of the facilitators were outlined, and that made learning easier. A study aimed at analysing relationship between students and preceptors in terms of support revealed that students gained a lot from role modelling of the preceptors (Kemper, 2007:10). Students also could reflect in terms of

finding quietness and peace of which they could access it by themselves and from the preceptors as well. According to this study, the students benefited from the reflection and therefore learning took place.

Brown, Herd, Humphries and Paton (2005:84) in their study focused on the role of the lecturer as perceived and experienced by students. As the lecturer took the role of a preceptor in the clinical units, every student in the unit of placement could be contacted regularly; as such the lecturer- preceptor played a very crucial role of supporting the students. This is basically what all students need to acquire competency. The problem of confusion over whose responsibility it is in terms of accompaniment between the unit managers and educators led to the undertaking of a study. A preceptor was chosen to accompany students for each unit. Cele, Gumede and Kubheka (2002:41) investigated into the responsibility of the preceptor to assess if the problems of the students were solved. The problems were solved that is why these researchers recommended that all training institutions establish preceptors in the units to support students.

Similarly, the study by Örhling and Hallberg (2000:228) investigated on lived experiences of preceptors which revealed that the students enjoyed the support they got as the receptors fulfilled the varied learning needs of the students, and most importantly, the preceptors maintained a balance on their professional and facilitation demands; and continued taking the responsibility of their own learning also. It is quite true that facilitators should keep up with new developments if they are to be valuable to their learners.

Preceptorship appears to be mostly valued by training institutions the best strategy to close the gap of lack of accompaniment, as Setswe (2002: 33) indicated the satisfaction of students on having realised that their learning needs were met. In the same breath, the study by Örhling and Hallberg (2000:228), which investigated on lived experiences of preceptors, revealed that the students enjoyed the support they got as the receptors fulfilled the varied learning needs of the students. And most importantly, the preceptors maintained a balance on their professional and facilitation demands; and continued taking the responsibility of their own learning also. It is quite true that facilitators should keep up with new developments if they are to be valuable to their learners.

Smedly (2008:185) also conducted a study whereby a certain institution developed a programme to train its preceptors, because they considered the role and function of a preceptor as vital to the professional preparation of nurses. The preceptor will facilitate the development of knowledge, clinical skills, professional attitudes and personal development of the student; so far it seems the role of a preceptor is indispensable if accompaniment is to be efficiently implemented.

Critical thinking gives students the capacity to analyse data then plan for nursing care based on the data collected. Uys and Meyer (2005:11) researched on methods used to enhance critical thinking. The outcome revealed that critical thinking and facilitation were not interpreted the same way by the participants, and that learning was not according to the principles of outcomes based education where learners must be actively involved in the learning process. The idea of critical thinking is relevant, as students have to apply critical thinking in their efforts to plan for nursing intervention.

Similarly, the study by Wilkinson (2004:36) also suggests use of theories of adult learning that would support students in their endeavour to use critical thinking in their daily execution of clinical practice. This approach helped students to understand the need of expertise in clinical situations. So, in all situations, studies are driven by the need to help students to acquire clinical skills.

Preparation of students for clinical placements is deemed important for the sake of supporting them. Research undertaken revealed that such preparation served as empowerment to students; as such, recommendation revealed the need for relevant preparation of students and clinicians through preceptor programmes programmed and implemented. It is interesting to note that effective communication as a means of support is highlighted (Pearson, 1998:45).

On the contrary, the study by Stockhausen (2005:8) suggests the importance of students to give their significant experiences; in that instance, students would reflect on their personal identity of becoming a nurse, developing the necessary confidence, clinical skills and the relevant knowledge. The significance of the study is that the experiences provided the clinical staff and educators with information considered valuable to design meaningful clinical learning experiences.

The study conducted by Murathi, Davhana-Maselesele and Netshandama (2005:13) investigated into the experiences of unit managers in terms of accompaniment. The findings revealed problems that have already been discovered by other researchers. For the first time, instead of preceptors mentioned, there was an involvement of unit managers in clinical teaching in planned programmes like seminars and workshops organised in the college, and an involvement of unit managers in formative and summative assessments.

In the same manner, the study by Corlett (2000:499) investigated on the theory-practice gap, as to whether it is negative or positive. The findings indicated a negative impact; as such, recommendations were made of developing an innovative curriculum and evaluating the necessary length of stay at clinical placements to acquire skills.

From studies undertaken, some problems and uncertainties were discovered as far as accompaniment is concerned. Further research is needed to explore into the stumbling blocks, so as to ensure that the learning needs of students are satisfied through accompaniment, as according to criteria laid down by the professional standards. In some institutions, when this problem was identified, research was undertaken with students involved in their choice of best alternatives models for accompaniment, and that rescued them.

The literature review in this study has assisted in assessing the extend of problems related to accompaniment from previous studies, and further assisted in realising the extend that accompaniment was utilised as a pillar for supporting students for institutions that experienced success. Literature review also served as a guide to understand the broader meaning of accompaniment to students, facilitators, institution managers and to the future generation of nurses.

2.7 CONCLUSION

Based on the literature review, it became clear that the plight of students in terms of accompaniment resulted from lack of clearly defined roles of service personnel and support; lack of training of the preceptors or mentors in their accompaniment roles; and lack of quality assurance as feedback to satisfy the learning needs of the students. There

was an outcry of the service registered nurse that there was no support from neither the academic personnel nor the service management.

It also goes without saying that accompaniment of the student is a responsibility that must be satisfied by those given the mandate. Given the huge responsibility as far as accompaniment is concerned, in other institutions mentors and preceptors are allocated to specifically deal with accompaniment. It is, therefore, important that effective accompaniment is made a priority to ensure clinically proficient nurses.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter presents the research design, population, sampling, sampling technique, data collection, ethical consideration and data analysis. The research design selected provide the plan in terms of how the researcher intends conducting the research which is the qualitative exploratory and descriptive design (Mouton & Prozesky, 2005:74). In the process of data collection, the research methodology is outlined to explain the methods used to conduct this research, meaning the how part of how data will be collected.

3.2 PURPOSE, OBJECTIVES AND QUESTIONS OF THE RESEARCH

3.2.1 Research purpose

The purpose of the study is to explore and describe the experiences of bridging course nursing students on accompaniment in the clinical setting.

3.2.2 Research objectives

The following objectives were set:

- To explore and describe the experiences of bridging course students about clinical accompaniment
- To make recommendations that would facilitate accompaniment of students

3.2.3 Research questions

The participants were asked questions, where in answering they were expected to describe their experiences, therefore enabled the researcher to obtain necessary data on their accompaniment. The questions were as follows:

- How did accompaniment influence your acquiring of clinical skills?
- What do you think the role of the unit manager should be in terms of accompaniment?
- What do you think the role of the nurse educator should be in terms of accompaniment?
- Is there anything that you would like to say in terms of your accompaniment experience?

3.3 RESEARCH DESIGN

Research design refers to series of decisions made by the researcher as to how the study will be conducted and implemented (Mouton & Prozesky, 2005:74). The design focuses the researcher on the end product, that is, the study as planned and the results, and it assists the researcher to focus on the tradition of the research as according to the design (Mouton & Prozesky, 2005:7). The nature of the design selected in this study is an explorative, descriptive, qualitative contextual research design.

3.3.1 Qualitative design

According to Polit and Beck (2004:16), qualitative research design is a naturalistic investigation that lays emphasis on the understanding of the human experience, as it is lived, through careful collection and analysis of narrative and subjective qualitative materials. According to naturalistic tradition, humans have inherent complexity whereby they are able to shape and create their own experiences, with the result that ideas projected become the truth that is a composite of realities. Burns and Grove (2005:23) indicate that this design best promotes understanding of human nature, as narration facilitates understanding of the experience, and meaning attached to experiences. The researcher has interest in the interactive and subjective nature of this design as it allows

participants to narrate their experiences; and thus facilitates understanding of human beings in terms of their uniqueness, holistic nature and dynamic forces.

In this study, the researcher discerned the qualitative design as compatible for the study because:

- In terms of ontology, there was a need for the emic perspective of the lived experiences of bridging course nursing students about clinical accompaniment in clinical setting. It was desirable that the process and context of the experience of students in their natural habitat are understood.
- Due to its interactive and subjective nature, it allows participants to narrate their experiences; so that human beings can be understood in terms of their uniqueness, holistic nature and dynamic forces (Burns & Grove, 2005:23).

It is important to note that the descriptive qualitative study design chosen does not follow a particular disciplinary or a tradition, in this regard the researcher focuses mainly on content analysis of the qualitative data, that means the analysis of themes and patterns that emerge (Polit & Beck, 2004:263). This qualitative study is based on premises of the naturalistic inquiry.

3.3.2 Exploratory design

Explorative research seeks to explore a topic or a problem in order to provide familiarity (Mouton & Prozesky, 2005:82). The researcher explored into the topic of accompaniment and as well as trends and aspects related to accompaniment in order to promote better understanding of the problem and to explicate on central concepts. Exploration into the problem satisfies the researcher's curiosity and desire to clearer understanding of the phenomena (Mouton & Prozesky, 2005:79).

3.3.3 Descriptive design

In qualitative research, descriptive studies open up a world of knowledge for the reader through which detailed and concrete descriptions of the phenomena could be viewed (Denzil & Lincoln, 2000:97). According to De Vos et al. (2005:106), "descriptive design

allows the participants to narrate their experiences fully". In this regard, the researcher used narrations given to describe the research, and by so doing seeking to describe the phenomena.

3.3.4 Contextual design

Context represents the setting, that is, the location within which the phenomenon is studied. It provides an understanding of where, how and the circumstances under which the human meanings are moulded. Context becomes the framework, the reference point, and the map. It is used to provide space and time for activities to take place and as a resource for understanding what the people say and do at that time in that space (Patton, 2002:62). The context is rich with clues for interpreting the experiences of the participants (Patton, 2002:63). By looking at the context the researcher is primarily concerned with the outcomes of the phenomenon (Bogdan & Biklen, 1999:213). Specific conditions that may arise and be applicable to actions, time, space and environment are considered (Holloway & Wheeler, 2010:193).

Context is therefore only valid within the time and place in which the phenomenon happens. Consequently, this study's context is the clinical setting where clinical accompaniment of bridging course students in Limpopo Province takes place (De Vos, 2000:201). The researcher described the context of this study, including the background in chapter 1.

3.4 RESEARCH METHOD

Polit and Beck (2004:723) describe research methods as steps, procedures and strategies for gathering and analysing data for research. The steps involve, deciding on a topic, population, sampling, and data collection including instruments to collect data and methods of analysing data. Procedures include measures to consider ethical issues and trustworthiness of the study. Strategies include determination of type of interview, whether unstructured or semi structured types of data, unit of data collection, data collection points, length of time for data collection, data recording and salient field issues (De Vos et al., 2005:287; Polit & Beck, 2004:333).

Given below are the research methods that the researcher used in the collection of data.

3.4.1 Population

In order to answer the research question, individuals, objects or elements that can shed light to the phenomenon under study have to be identified. These are termed the 'research population'. Polit and Beck (2004:287) describe population as "the entire aggregation of cases in which a researcher is interested". The population can range from humans, hospital files, blood samples, hospitals to clinics. In this way, terminology referring to population' includes 'universal population', sometimes called the 'target population' and the 'accessible population' (De Vos, 2000:198). Target population refers to all elements with the attributes that the researcher is interested in (De Vos, 2000:198). Within the target population, there is accessible population, which refers to the portion of the target population to which the researcher has reasonable access to. In this instance, the accessible population becomes practical for sampling (Brink, 2006:130).

The accessible population for this study comprises students registered for the *Bridging Course for Enrolled Nurses* (Regulation R.683 of 1989, as amended) in their final year of study, in one of the 7 hospitals in the Sekhukhune District, Limpopo Province (SANC, 2006).

3.4.2 Sampling and sampling technique

Sampling is a subset of people drawn from a larger population considered to be representative of the accessible population (Stommel & Willis, 2004:296), whereas the sampling technique refers to the process of selecting a portion of the population to represent the entire population. There are two types of sampling, namely, probability sampling and non-probability sampling.

In qualitative research, the sample size is a question of purpose of inquiry, the quality of the participants as well as the type of strategy for sampling used (Polit & Beck, 2004:308). Another criterion for sampling is data saturation, which means a point in data collection where new aspects of data cannot be found.

- **A purposive sampling**

In this study, a purposive and convenient sampling of 14 students, registered for *Bridging Course for Enrolled Nurses* leading to registration as a general nurse (Regulation R.683 of 1989, as amended), in one of the 7 hospitals at the Sekhukhune district was conducted (SANC, 2006). A purposive sampling helped the researcher to select the sample that has typical knowledge for data needed for the study.

The logic and power of purposeful sampling lie in selecting information-rich cases for in-depth study (Patton, 2002:230; Henning et al., 2004:45). Furthermore, the sampling approach is used based on the judgment of the researcher to look for elements that fit the criteria (De Vos, 2000:99) and will provide the needed information. This criterion assume that the researcher's knowledge of the topic, the population, its characteristics and the nature of the research purpose is sufficient to enable her to select cases deemed to be meeting the inclusion criteria (De Vos, 2000:99). As such, purposive sampling is selected because participants will offer useful manifestations of the phenomenon of interest and will respond to the research questions relevantly and shed light in the understanding of phenomena (Creswell, 2003:185).

Purposive sampling is then aimed at obtaining insight about the phenomenon and not about empirical generalisation from a sample population (LoBiondo-Wood & Haber, 2002:246). Data saturation was reached at 14 participants. Networking aided in finding cases that have rich data and are willing to give information for the sake of the research. Such cases should have necessary insight into the researched topic (Burns & Grove, 2005:353).

- **Inclusion criterion**

An inclusion criterion gives direction of a list of the characteristics essential for inclusion in the sample (Burns & Grove, 2005:336). The following were the criteria for inclusion:

- Bridging course students in their second year of study because of their long exposure in training would help to give rich data (Burns & Grove, 2005:352)
- All those who were willing to participate

- There was no restriction in terms of age, race, religion, gender, social status or creed

3.4.3 Data collection

Data collection is a process whereby information pertaining to a phenomenon is sourced through instruments such as interview schedules and guides, questionnaires, records, artefacts, observations and field notes. The method and instruments for data collection are determined by the research design and research approach, which can either be qualitative or quantitative or both. Situations wherein both approaches are used, the methods usually complement each other. Data collection in qualitative research refers to collecting of information in the form of interviews because the researcher has interest in other people's stories. The interviews become the interactional medium for data collection where the researcher has a responsibility to create meanings from data reflected by participants (De Vos et al., 2005:287).

An interview is a constructive conversation between two people or groups with one person or group guiding this conversation. There are two types of interviews, that is a structured interview, where an interview schedule with a written list of open and/or closed question is used or unstructured interviews where an interview guide that may have one or more leading question(s) is used. The question(s) open(s) a conversation and paves the way for probing questions.

In this study, a semi-structured interview was used. The researcher asked open ended questions for participants to narrate their responses during the interview (Burns & Grove, 2005:541). The open ended questions enabled the respondents describe their experiences in thick descriptions.

3.4.3.1 Data collection approach

The data collection approach as in descriptive qualitative studies follow the trend in ethnography research traditions (Polit & Beck, 2004:77). This trend is followed as descriptive questions are going to be asked. Students were expected to describe their experiences in terms of accompaniment.

3.4.3.2 *Building rapport*

Firstly, a quiet environment was chosen and agreed upon with the respondents, that could offer privacy, and the respondents were comfortable with the seating arrangement that encouraged involvement and interaction. The researcher also helped the respondent to relax by starting with ice breaking activities, for example local events that enjoyed much publicity. The researcher established rapport by being attentive, listening, showing interest, understanding and respect of what the participant is saying. Furthermore, the researcher allowed the respondents to finish what they were saying at their own rate of thinking and speaking (De Vos et al., 2005:295).

3.4.3.3 *Emotional involvement with participants*

Getting too emotionally involved with the participants was avoided (Polit & Beck, 2004:335). The researcher avoided the risk that would prevent objective collection of data and thus make one become overwhelmed with circumstances of the respondents by listening and being supportive. Where there were problems, the researcher referred the participants to relevant professionals, instead of trying to solve the problems.

3.4.3.4 *Conducting effective interview*

Chatting before the interview helped the participants to be at ease as such established a warm and comfortable rapport. The researcher was relaxed, affirmative and natural as much as possible to create an environment that is conducive for the participants. Showing participants appreciation and respect was essential, so the researcher showed these through words and actions that each respondent is really an integral part of the researcher. The researcher was cordial and appreciative enough by thanking the participant after collecting data and also answered questions honestly (Burns & Grove, 2005:543). Listening skills of the researcher promote fluid communication. Minimal verbal responses that correlate with occasional nodding, for example, “mmm, I see”, affirmed that the researcher was really listening. The researcher endeavoured to make statements of encouragement to the participants as interviewing can be tiring, so as to motivate the respondent to continue (De Vos et al., 2005:291).

Where clarity was needed, the researcher made use of communication techniques that included:

- Paraphrasing, the researcher shall state words in another form with the same meaning.
- Getting clarity on unclear statements, for example, “could you expand more about this experience”?
- Reflection, reflecting back on something so that the participant can expand, for example, so, “you believe accompaniment was not done”?
- Reflective summary, summarising the participants’ ideas, thoughts, and feelings transpired so far to ensure that what was said was understood.
- Probing was done to persuade the participant to give more data about the issue being discussed, for example, contradicting, linking, faking puzzlement, challenging, acknowledging, procuring details, direct questioning, and showing understanding and allowing time for elaboration.

(De Vos et al., 2005:292)

Semi-structured interview

Semi-structured interview is a set of questions prepared before for interview with the sequence influenced by the course of the interview (Stommel & Willis, 2004:245). The researcher used semi structured interview where the researcher have predetermined questions for interview schedule. The researcher and participants enjoyed a lot of flexibility, whereby the researcher followed interesting avenues that emerge in the interview and, the participants gave more rounded and fuller picture of data provided. All questions were open ended. The researcher facilitated opening up of the participants for explanations in order to obtain data needed, and the participants were given the maximum opportunity to narrate (De Vos et al., 2005:296).

Characteristics of the data collecting instrument

The semi-structured interview facilitates in gaining of participants’ picture of beliefs, perceptions and accounts of a given topic, as such it affords the researcher and the

participant more flexibility (De Vos et al., 2005:296). The researcher had the opportunity to follow up interesting avenues that emerge with the participant enjoying to give rich descriptions, as such the participant becomes more relaxed to narrate whatever is required based on experiences.

Although the researcher had predetermined questions for the interview it is the schedule that guides the interview rather than the questions, for that reason De Vos et al. (2005:296) indicate that “the participant shares more closely in the direction the interview takes and he can introduce an issue the researcher has not thought about”. In addition to predetermined set of questions, probes are used to get more information or to make some clarifications (Stommel & Wills, 2004:245).

Observations

Observations were done in the field to confirm if what the participants say correlate with their facial gestures. Observations were also done to capture facial gestures that could underpin certain emotions (Polit & Beck, 2004:378).

Data recording

Audio recording was used to ensure that interview reflect the actual verbatim responses of study participants. A tape recorder was used after a written consent was obtained from the participants that allowed the researcher to record the interview.

3.4.4 Ethical considerations

The science of ethics is concerned with the manner of conducting research (Mouton, 2002:238). Scientific research is part of human conduct. It is therefore imperative that a researcher, in the endeavour to search for the truth, should not do so at the expense of research participants. Accordingly, for this study, before commencing with fieldwork, it was necessary to seek and gain ethical approval from the relevant authorities, the Department of Health and Social Development in Limpopo province, and the Chief Executive Officer at a hospital in Sekhukhune district to ensure that the rights of the participants are protected. In addition to this, *The Constitution of the Republic of South*

Africa (Act no 108 of 2005) indicates that protection of the citizen is a basic human right. Furthermore, nurse researchers have an ethical responsibility to the nursing discipline (Jackson, 2003:86).

Ethics is therefore associated with morality in terms of what is the right or wrong. Herbst (2000:87) refers to ethics as “the study of general nature of morals and of the specific moral choices to be made by the individual”. In terms of scientific research, ethical considerations become the general agreement by researchers in terms of what is proper or improper in undertaking a scientific inquiry (Mouton & Prozesky, 2005:520).

The most important ethical considerations are, viz., voluntary participation; anonymity and confidentiality; and avoiding to do harm to the participants.

- **Securing permission to conduct the study**

Ethical clearance was first obtained from the Department of Health Studies Research and Ethics Committee after the proposal was accepted by the Department of Health Studies Research and Ethics Committee. As the sample was obtained from within a governmental institution, permission to conduct the research was first obtained from Department of Health in Limpopo Province, then finally from the institution where the data was to be collected. The institution was assured that the name of the institution will be kept confidential as well as that of the participants (Stommel & Willis, 2004:289).

- **Securing informed consent**

A written consent was obtained from the participants for participating in the research, after they were given information on the nature of the research and what is expected of them. Participants were made aware that participating in the study is voluntary. All that was required of them was to describe their accompaniment experiences. The researcher also indicated that a recorder will be used to capture information, so that the researcher would be able to access the information for analysis purposes.

The researcher indicated the benefits of participating in the research that the study might assist in improvement of accompaniment. They had to decide on their own if they

preferred to participate in the study; and if they preferred not to participate they would not be harmed in any way (Stommel & Willis, 2004:289). Non-participation would not compromise them in any way. They were assured that they would be no victimisation for not participating in the study (De Vos et al., 2005:59).

- **Privacy/confidentiality and anonymity**

All students who agreed to participate in this research were assured that their names or identity will be subject to confidentiality. Any information narrated shall not be reflected with the names of the participants; thus their identity will be protected (Stommel & Willis, 2004:289). Participants were assured that they have a right to withdraw from the study any time that they wish to with no untoward consequences (Polit & Beck, 2004:149). However, the researcher made it clear to the participants that as consumers of the service they are in a better position to share experiences on the phenomenon under study.

The participants were treated with respect in terms of how they respond to questions made to them, how they determine their actions and choices (Tjale & De Villiers, 2004:10). Fair treatment and privacy was maintained. All the participants will be treated with respect and dignity, and the interviews were conducted at a private place. All information was kept confidential. The participants were also told that the tape recorder used will be kept confidential and will be destroyed after the study is completed.

The study's background, purpose, objectives, methodology, ethical considerations and reporting system will be explained (Polit & Beck, 2004:151). An outline of the study's background, purpose, objectives, methodology, ethical considerations and reporting system was done, so that the participants understand fully the study to can give consent to participate in the study, thus they must give informed consent. The participants were told to be free to ask questions where they need clarity on any aspect of the study, to ensure that they understand every aspect of the study before the commencement of the data collection process (Stommel & Willis, 2004:289).

Below follows ethical considerations related to data collection:

Privacy and confidentiality

The participants were told that the information they share would not be made available to any person and their names would not appear on the documents. All information was promised to be destroyed upon completion of the study. The tapes used for recording would be destroyed after the study, and the transcribed notes would only be made available to the independent coder (Stommel & Willis, 2004:289).

3.4.5 Data analysis

The aim of qualitative analysis is to organise the data provided so that it can be interpreted to give meaning. In case of qualitative analysis, collection of data and analysis occur simultaneously, thus the search for important concepts and themes start from the time when data collection begins (Polit & Beck, 2004:570). De Vos et al. (2005:335) explain data analysis as involving a two-fold approach: the first approach depicts data analysis at the research site, and the second approach involves data analysis following a period of data collection away from the research site.

It must be clear that in order to establish a coherent interpretation of data, data collection and analysis must go hand in hand. According to Mellish et al. (2002:436), as cited by De Vos et al. (2005:335), data analysis starts when the researcher is still in the field. Immersion in the data is part of the process of data analysis, and is regarded as important, as it gives the researcher an opportunity to “get a feel of the cumulative data as whole” (De Vos et al., 2005:337). Furthermore, De Vos et al. (2005:337) cite Creswell as quoting Agar (1980) indicating that a researcher must immerse in the data by reading the transcripts several times.

Open coding was used in the process of data analysis whereby the researcher reads through all transcripts to obtain a broad idea of what the interviews were about. The researcher critically read each interview, identifying themes and subthemes and words related to the experiences. Similar themes and words were then clustered into categories, then translated into scientific descriptions (Mouton & Prozesky, 2005:499). De Vos et al.

(2005:336) cite Creswell (1998:144) as saying relationships amongst categories that emerge in the research process are used to form tentative propositions, then those statements can be written on the cards, then sorted into categories. The researcher was assisted by an independent decoder and supervisor to ensure coherent of data.

3.4.6 Rigor and trustworthiness

Mouton and Prozesky (2005:276) cite Lincoln and Guba (1985) concerning objectivity in qualitative studies, that a good qualitative research is determined by its trustworthiness, that is, the neutrality in terms of the findings and decisions related to the study. By means of trustworthiness, the researcher persuades the readers that the findings need to be considered.

According to Stommel and Willis (2004:288), qualitative research must conform to replicability, which is the criterion for assessment of data quality, which includes study design and data collection methods to find out if study can replicate the same results in another context. For the same reason, Stommel and Willis (2004:288) cite Lincoln and Guba (1985) on their widely used standards or criteria for data quality known as:

- Confirmability
- Dependability
- Transferability
- Credibility

The above-mentioned are described as follows:

Confirmability

Confirmability refers to objectivity of data such that two or more independent people can reach congruency about data's accuracy, meaning and relevance on the study undertaken (Polit & Beck, 2004:435). Audit trail is used to establish the confirmability of the data, by means of inquiry audits that entails a systematic collection of relevant documents and materials that guides the independent auditor to make conclusions about the data

collected. In this case, the supervisor and the co supervisor will serve as auditors to ensure confirmability of this study.

Dependability

Dependability refers to the maintenance of stability of data with aspects such as time and conditions. To ensure the dependability of this research, a stepwise replication will be done, the research teams, about two, will subject the data sources separately and conduct inquiries as well as comparing data, to see if they can reach the same conclusions as the researcher (Polit & Beck, 2004:435). The audit trail can also be used to ensure dependability of the study. According to Mouton and Prozesky (2005:278), the auditors as my supervisors, assess the data, findings and interpretations thus:

Transferability

Transferability means generalisation of data to find out if the same findings will apply in the other settings or groups. The researcher provided thick description to ensure transferability of the study. The researcher had also ensured purposive sampling to ensure that rich data is obtained from participants (Mouton & Prozesky, 2005:277).

Credibility

Polit and Beck (2004:48) refers to credibility as “the truth of the data and interpretations of them”. In other words credibility strikes a balance between data provided and findings and interpretations by the researcher. Polit and Beck (2004:48) (cite Lincoln & Guba, 1985) that credibility also involves assessing if the study was conducted in a manner that promotes credibility, including the steps undertaken. A number of techniques are involved in ensuring that the study is credible to the readers.

Prolonged engagement in varied field experience

The researcher has a prolonged and extended practising experience in the area in which the study was done and conducted interviews until data were saturated (Van Rooyen, Nomqokwana, Kotze & Carlson, 2006:6).

Prolonged engagement in the study

The researcher stayed in the field until data saturation was reached, and dwelling in the study helped to build rapport and trust; thus informants were free to give more useful, accurate and rich information data (Polit & Beck, 2004:43).

Referential adequacy

Referential adequacy refers to materials where findings were captured. In this case, the researcher captured data on cassettes as a tape recorder was used (Mouton & Prozesky, 2005:277).

Authority of the researcher

The researcher used the guidance of the supervisor and colleagues who are experienced, from the University of South Africa. In addition, the researcher attended a research seminar for one week, and passed a paper on principles and methodology of research in postgraduate degree (Honours degree in Health Studies).

3.5 CONCLUSION

This chapter reflected the research methodology and design. Data were also collected accordingly. As a tape recorder was used to capture data, some of the participants appeared not to be free when the interview started, but eventually became relaxed as the interview continued. It was interesting to listen to concerns made by the students. Some participants gave thick descriptions about their concerns, whereas others were in a state of apprehension and were not free to elaborate lengthily on their experiences, even though the researcher tried to be as friendly and warmly as possible. Data analysis indicated gaps as far as accompaniment is concerned.

This chapter presented selected research design, research methodology and touched data analysis as a step in research methods, and the other reason being that with the qualitative design collection of data occur on the field in order that transcribing and

analysing of the interviews can be done while they are still fresh in memory. The next chapter deals with data analysis in full.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

Having described the research design and methodology in chapter 3, this chapter presents the data analysis and interpretation as well as findings of the participants' experiences of clinical accompaniment. The purpose of data analysis is to organise order on a large body of information, so that conclusions can be reached and communicated in a research report (Polit & Hungler, 2003:500). The research results are discussed supported by published research work from literature, so as to demonstrate the usefulness and implications of the findings (Morse & Field, 1996:106). The purpose is to confirm the findings and indicate those unique to the study. Since in qualitative research literature control is used inductively with relevance to the specific research paradigm, the research findings will be discussed with reference to the literature (De Vos et al., 2005:337).

The data was analysed firstly by identifying themes from the data, also called open coding (De Vos et al., 2005:336), then data were divided into paragraphs and sentences with the same meaning, sorted into categories and then coded.

The study wished to answer the research question *what are the Bridging course student nurses' experiences of clinical accompaniment in the clinical setting?* In order to do that, a semi structured interview, with questions, guided the researcher to conduct the research.

Data were analysed using steps as described by De Vos et al. (2005:334), citing Creswell (1998:142), indicating the steps as follows:

- Managing or organising the data
- Reading and writing memos
- Generating categories' themes and patterns
- Coding the data

- Testing the emergent understanding
- Searching for alternative explanations
- Writing the report

The above-mentioned are described as follows:

Managing or organising the data

Since data were captured using a tape recorder, the audiotapes were transcribed verbatim. The researcher was afforded an opportunity to immerse in the data when typing and organising data. The researcher then saved two copies, one put away for safekeeping, the other one used for cutting and pasting (De Vos et al., 2005:336).

Reading and writing memos

The transcripts were read several times, as such the researcher immersed in the data so as to get sense out of the interview, and breaking it into parts. The researcher wrote memos which are short phrases consisting of ideas or key concepts that emerge (De Vos et al., 2005:337).

Generating categories, themes and patterns

The text was taken apart and a search was started to look for categories, themes or dimensions of information. Analysis meant the text was classified into several themes, the themes also divided into subthemes representing segments of data, reducing information to manageable themes ultimately for report writing.

Coding the data

Categories and themes were generated using codes, for example, key words were used, and thus the researcher saw a new understanding emerge during coding of the data.

Testing emergent understanding

The researcher searched through the data to ascertain if there is understanding, if there is sense, then also searched for negative instances of the patterns, so that they can be incorporated into larger constructs (De Vos et al., 2005:338).

Searching for alternative explanations

Even though the categories and patterns were discovered, the researcher searched for other plausible explanations and linkages, so that they can also be identified and described.

Writing the report

The researcher then finally presented the data of the findings in a table, what is also known as a visual image of the information (De Vos et al., 2005:339).

4.2 PARTICIPANTS' PROFILE

4.2.1 Gender, language and years of training

The table below displays the gender, language and year of commencement training of training. The respondents were fourteen, purposefully invited to participate. Burns and Grove (2005:306) consider a sample purposive when participants are consciously selected in qualitative research.

Table 4.1 Respondents' gender, language and year of commencement of training

Gender	Number of students	Year of commencement of training		Language		
		2006	2007	Sepedi	Tswana	Ndebele
Male	4	1	3	4	-	-
Female	10	-	10	8	1	1
Total	14	1	13	12	1	1

During the interview initially, most students were nervous, as such, only a few gave positive comments only but most students tried to speak their minds even though they were under tension. As the training institution is in Limpopo, most of the students speak Sepedi and, in terms of gender, females are more because nursing is still predominately a female profession.

4.3 DATA MANAGEMENT AND ANALYSIS

Themes and subthemes

One central theme identified is that the students experienced dissatisfaction in terms of their development of clinical skills to competence as they were not given an opportunity due to negative circumstances around their training. Table 4.2 presents categories of themes and sub-themes that emerged.

Table 4.2 Themes, subthemes and categories

Category	Theme	Subtheme
4.3.1 Lack of support from unit managers	4.3.1.1 Students' challenges in relation to the unit managers	4.3.1.1.1 Most of the time the unit managers are absent from the ward 4.3.1.1.2 Accompaniment not done consistently due to shortage of unit managers 4.3.1.1.3 Lack of interest of some of the unit managers in accompaniment 4.3.1.1.4 Students used as work force as their learning needs not attended to 4.3.1.1.5 Lack of knowledge of unit managers in terms of their teaching role 4.3.1.1.6 Teaching programmes either not available or the programme not according to the learning needs
4.3.2 Lack of support from nurse educators	4.3.2.1 Students' challenges in relation to nurse educators	4.3.2.1.1 Nurse educators provide insufficient time for accompaniment 4.3.2.1.2 Nurse educators do not come as expected 4.3.2.1.3 Nurse educators are not enough 4.3.2.1.4 Nurse educators not active enough 4.3.2.1.5 Nurse educators not clinically competent
4.3.3 Lack of equipment	4.3.3.1 Students' challenges in relation to lack of equipment	4.3.3.1.1 Lack of equipment impacted on learning of clinical skills 4.3.3.3.2 The problem of lack of equipment not attended to 4.3.3.3.3 Lack of equipment impacted on placements of students in some units

Category	Theme	Subtheme
4.3.4 Lack of support from management	4.3.4.1 Students' challenges in relation to leadership role of management	4.3.4.1.1 Management does not ensure that units are fully equipped 4.3.4.1.2 Management does not ensure that there are enough professional nurses and nurse educators 4.3.4.1.3 No supervision role into teaching role of the unit manager and nurse educators 4.3.4.1.4 No in-service education to empower the unit managers in their teaching role
4.3.5 Lack of support from the doctors	4.3.5.1 Students' challenges in relation to doctors involvement in accompaniment	4.3.5.1.2 Some doctors do not support learning experience for student

4.3.1 Discussion of the themes and categories

4.3.1.1 Theme: Students' challenges in relation to the unit managers

Table 4.3 Challenges experienced by the students

Category	Theme	Subtheme
4.3.1 Lack of support from unit managers	4.3.1.1 Students' challenges in relation to the unit managers	4.3.1.1.1 Most of the time the unit managers are absent from the ward 4.3.1.1.2 Accompaniment not done consistently due to shortage of unit managers 4.3.1.1.3 Lack of interest of some of the unit managers in accompaniment 4.3.1.1.4 Students used as work force as their learning needs not attended to 4.3.1.1.5 Lack of knowledge of unit managers in terms of their teaching role 4.3.1.1.6 Teaching programmes either not available or the programme not according to the learning needs

Most students experienced challenges in relation to unit managers as reflected in the above table, though they mentioned that in other units they were supported. Few students mentioned that they received support from all the units, and only one student mentioned that there was no support at all from all the units.

4.3.1.1.1 *Most of the time unit managers are absent from the ward*

Students complained of being left alone, to an extent that they had to manage the units, whereas they have to practice under their supervision.

“In some units the sisters ... they are having quite a shortage, sometimes the sisters are not on duty, so we have to run the units”.

A student practices nursing procedures under the direct and indirect supervision of the unit manager and other professional nurses allocated to the unit. Direct supervision occurs when the student is still learning to acquire the skill and indirect supervision when the student has acquired the skill. According to Mellish et al. (2000:209), the unit manager should be present at all times to supervise the unit in terms of facilitation of learning and patient care, thus serve as a role model.

Besides the absence of the registered nurses due to shortage, there are other reasons, having to attend meetings, and students are left alone.

“If I can say they are having time, even though the time that they are offering is insufficient. Most of the time they have to move outside the ward situation, maybe going outside to attend meetings, only to find that the students are left alone in the department”.

The unit manager as a supervisor of the unit or ward provides supervision in the unit that is aimed at developing the student into a clinically competent nurse practitioner. Processes that are involved are facilitation of learning, observation, analysis, assessment, giving of feedback, modelling and mutual problem solving (Falender & Shrafraske, 2004:3). If the unit manager is not in the unit with the students, students felt neglected as they need to practice nursing care skills under supervision of the unit manager or any registered nurse allocated to the unit, they should not be left with no supervision of a registered nurse.

According to the guidelines supplied by the SANC (Regulation R683, as amended), accompaniment is indispensable in all the units and all registered nurses should be directly involved in accompaniment (SANC, 2006).

4.3.1.1.2 *Accompaniment not done consistently due to shortage of unit managers*

Shortage of registered nurses negatively impacted on provision of clinical teaching as patient care and other issues were more of a priority.

“Sometimes we were encountering problems because of the shortage of staff, we were. Maybe the sister is busy and is alone in the ward, sometimes did not get a chance to help a lot as we may be expecting”.

The availability of the unit manager is crucial not only for the support of the students, but also for maintenance of quality patient care. So, the daily coverage of the unit by the unit manager ensures that the students achieve their learning objectives, and patients/clients receive expertise nursing care (Mellish et al., 2000:209).

The respondents were not taught as the registered nurses were busy with other responsibilities and the poor students were not taught:

“I think the unit managers should make it a point that they give us that support, but they cannot because they are insufficient, the allocation of the professional nurses in the clinical area is limited, let me say they are not enough”.

“Yes of course in the clinical area there is shortage of staff which influences us as students as we have to patch shortage, and as students we are unable to achieve learning objectives”.

4.3.1.1.3 *Lack of interest of the unit managers in accompaniment*

Students depend on guidance from the unit managers or registered nurses in the unit, in order to gain clinical skills, however, the unit manager lacked interest in their teaching role.

“Sometimes there are wards which the sisters I do not know what is happening, I don’t know if they don’t know the things the student must suppose to do, because they just seem as if the student just comes for

working not for learning, but some wards are responding and tabulate the teaching programme so that we can give feedback”.

“The problem that I had during accompaniment was that in some wards we were not actually accompanied and would like them to improve on such an instance”.

Clinical teaching for students is an inescapable responsibility for the unit manager, because as Quinn (2001:425) indicates, the clinical environment should promote competency for the personnel and students so that quality nursing care for the patients and clients will be executed according to the set standards. Students also need to be delegated according to their learning outcomes, where supervision is carried out throughout, assessments done and feedback given to direct the students (Graevette & Geysler, 2004:94). The unit managers frustrated the students as they displayed negative attitude towards accompaniment, and served as stumbling block for progress and competency of students. The students reflected their frustrations in the following *narration*:

“... once I was in Male Medical ward, in that ward really we were just workers not students ... the unit manager did not show us how to do we just copied from our colleagues in other wards. There was no support. Even the subordinates say you are going to pass using their knowledge. Maybe they think they are promoting us to the next level”.

“... and as students we feel that we are exploited, because we spent little time being treated as students by being taught, and we spent more time working on patients, so we feel we lose the privilege that we deserve as students in order to learn and be equipped and be ready to work as managers in the units”.

4.3.1.1.4 Students used as work force

Students' placement in the clinical area serves to afford them an opportunity to learn under guidance of the registered nurses working in the clinical area, but the students were used as work force.

“Yes of course in the clinical area there is shortage of staff which influenced us as students as we have to patch the shortage and as students we were unable to achieve learning objectives”.

“... and as students we feel that we are exploited, because we spent little time being treated as students by being taught, and we spent more time working on patients, so we feel we lose the privilege that we deserve as students in order to learn and be equipped and be ready to work as managers in the units”.

Students are placed in the units for the purpose of learning, so that they cover their learning outcomes according to the skills to be learnt in that particular unit, and through the support of the unit manager accompanying them to the patients, they will be able to acquire those skills (Mellish et al., 2000:213). Lack of support frustrated the students and also put the safety of the patients at risk.

4.3.1.1.5 Perceived lack of knowledge of unit managers in terms of their teaching role

In a training institution the unit managers has to accompany students for teaching and assessments, but from students' experiences some unit managers did not play their teaching role.

“... the unit manager did not show us how to do, we copied from our colleagues in other wards, and there was no support. Usually when you ask them, because even the subordinates say you are going to pass using their knowledge. Maybe they think they are promoting us to the next level. So, they left us on our own doing everything”.

“I ended up thinking that maybe they do not have the knowledge that is why they are afraid to tell us something about the ward inspection”.

The unit manager has a teaching role entrusted on his or her shoulders to ensure that students placed in the units are able to acquire appropriate clinical skills, knowledge and attitude. The SANC guidelines (Regulation R.683, as amended) expects the unit manager

as a registered nurse to facilitate learning of a student, thus creating learning opportunity and directly assists the student to optimise his/her learning outcomes (SANC, 2006).

Unfortunately for the students, some of the unit managers ignored their teaching role, as such the respondents as students indicated their frustrations as reflected in the following narrations:

“The role of the unit manager should be a role model, she must supervise the subordinates, not delegating the subordinates and not supervising them”.

“If all the unit managers might know that accompaniment is not only meant for tutors and students, maybe there will be an improvement”.

4.3.1.1.6 Teaching programmes were either not available or the programmes were not according to the learning outcomes

The unit manager should have a programme for accompaniment of the students, according to their expected learning outcomes; some unit managers did not have the programmes, so teaching was not done.

“Programmes were there but not in all the sections, as sometimes you find that the programmes ... and we expect to be trained in accordance with those programmes, but. But they are not followed, and as students we feel that we are exploited.”

“We were first given programmes, when we first arrived in the units, in other units really they don't give us programmes, and we have to ask the unit for programmes of which are not good.”

According to Mellish et al. (2000:218), a plan is crucial if clinical instruction is to be effective. That plan must be followed and it must be communicated to the students. The plan should have the following as prerequisites:

- Curriculum knowledge
- Consider learning outcomes at different levels and placements
- Clear definitions of general as well as specific objectives
- Incorporation of ward personnel with specific expertise in a formal programme
- Standardisation of nursing care procedures to facilitate nursing care and teaching
- Medical and paramedical personnel should be consulted so that they will be included in the programme
- The unit manager and other professional nurses under the management of the unit manager should participate actively in the programme, and programmes of continuous education in the form of in-service education should be put in place to keep personnel tuned to their responsibility
- Students should be informed of their responsibilities

The unit managers did not play their roles in this important aspect of assisting students to acquire nursing skills, consistently and according to the envisaged plan. The students narrated their experiences as follows:

“Like the ward I’m in now, I don’t have a teaching programme, the sister did not draw the teaching programme for us”.

4.3.2.1 Theme: Students’ challenges in relation to the nurse educators

Table 4.4 Students’ challenges in relation to the nurse educators

Category	Theme	Subtheme
4.3.2 Lack of support from nurse educators	4.3.2.1 Students’ challenges in relation to nurse educators	4.3.2.1.1 Nurse educators provide insufficient time for accompaniment
		4.3.2.1.2 Nurse educators do not come as expected
		4.3.2.1.3 Nurse educators are not enough
		4.3.2.1.4 Nurse educators not active enough
		4.3.2.1.5 Nurse educators not clinically competent

Most respondents indicated that the nurse educators did provide accompaniment, but indicated that the time for accompaniment was not enough, due to some of the reasons indicated in the table. Only very few students indicated that they did not encounter problems in terms of accompaniment conducted by the nurse educators.

4.3.2.1.1 *Nurse educators provide insufficient time for accompaniment*

Nurse educators are supposed to visit the clinical area when students are placed there, but they did not allocate enough time as expected.

“Eh ... the Nurse Educators they do come to the clinical area – they do come, but, it’s not enough, it is insufficient, for them to can come to move away from the school, ...”.

“If they can be with us all day, eh ... if they ... they may be enough we are so many groups, so if they can come in numbers so that every group has got a tutor, maybe we can come with something”.

The nurse educator should use time as indicated on clinical teaching programme to accompany students, based on the learning needs of the students, so that at the end of the learning activity the student is satisfied with the extend of facilitation given, and has gained from it leading to clinical competency. Mellish et al. (2000:76) speak of a nurse educator in her role as a leader as a “referee, detective, a diffuser of anxiety, a target for hostile feelings and frustrations, friend and confidante and ego supporter”. If the nurse educator does not allocate enough time for accompaniment the roles will not be played.

The presence of the nurse educator should also motivate them to explore the potential world of practice and knowledge, and also “to think, reflect, wonder, discover, fantasise, invent and reinterpret as they explore the potential world of practice and knowledge” (Mellish et al., 2000:76).

The respondents did not enjoy enough time to be with their nurse educators during accompaniment, thus they indicated the frustration in the following narrations:

“Sometimes they do have time, whereas in the other time they just refer us to the wards and they do not come to assess us what we have done”.

“They do so but the time is short ... They must allocate enough time, so that we will be able to learn”.

“Tutors are supposed to come so and correlate what they have been teaching us at the nursing school, so that we are able to observe the skills and acquire knowledge from what they taught us at nursing school”.

4.3.2.1.2 Nurse educators do not come as expected

Though programmes are there for accompaniment, they were not followed. Hence students complained thus:

“ ... for them to can come to move away from the school, the ... they ... they don't come as much as expected”.

“Sometimes they do have time, whereas in the other time they just refer us to the wards and they do not come to assess us what we have done”.

The important role of the nurse educator is to assist students to correlate theory into practice; however, the experiences of the respondents indicate that the nurse educators were not coming as expected, as observed in their narrations:

“They could come on some instances, but not always ... they do allow us to come to the college and ask questions if we have problems, when they cannot come”.

“According to me, I think they must demonstrate things to us during accompaniment, usually when we come with our nurse educators during accompaniment they usually give us tasks, and we do the tasks on our own. They leave us alone and when they come they ask us questions. Sometimes when we are all students, we don't know whether we are on the right track; we just do things abruptly, maybe you don't know what you are doing or the best reasons why you are doing this. So, according to me during accompaniment they must clearly show us what we must do during accompaniment ...”

Although physical presence and interaction of educators has benefits for student learning, research has revealed that contact with the educators even in residential institution is a problem. A study by Cassimjee and Bhengu (2006:47) revealed that 53% of the third and fourth year students in one residential university reported to have had no visit from its tutors for a period of three months. Twenty three percent (23%) of these students indicated that they did not even have a single visit from its clinical instructor in three months. This situation clearly indicates that a clinical accompaniment requirement for educators competes with the other responsibilities of the educator. This results in clinical teaching being secondary and frequently left to the discretion of mentors, and ward staff (Lambert & Glacken, 2005:664).

4.3.2.1.3 Nurse educators not enough

Shortage of nurse educators deprives the students of learning, as accompaniment is not done.

“... yes they were teaching us to be independent, though we have shortage of ... like our tutor was involved in accident, and we are not okay there and there...”.

“Hmm is the tutors, they are few, they must be added ... If they may be enough, we have been so many groups so, if they can come in numbers so that every group has got a tutor maybe we can come with something”.

The general shortage of nurses and of nurse educators in particular and their varied roles, impact negatively on the teaching and learning of students. Their varied roles include supervising classroom work, laboratory and clinical activities; planning, organising and planning and programming class work and clinical work preparing assessment exercises and tests, assignment and grades; liaising with colleagues, with service personnel and the community, attending meetings, attending courses and keeping records (Mellish et al., 2000:77).

The respondents appreciated these roles and understood the nurse educator's plights as expressed in the following statements:

“Eh ... the nurse educators gave us the support that we needed, even though the support is not enough. I see shortage on their side, they are not enough, and they are always preoccupied, so sometimes we just get a little percentage of their efforts, but they try their level best”.

4.3.2.1.4 Nurse educators not active enough

Active participation of the nurse educators stimulate active participation on the part of the students, the passivity of the nurse educators frustrated the students.

“Tutors are supposed to come and correlate what they have been teaching us at the Nursing School, so that we are able to observe the skills and acquire knowledge from what they taught us at Nursing School”.

“Also the tutors during accompaniment they must show that they are fully there and participate effectively”.

The SANC guidelines, with regard to the course *Bridging Course for Enrolled Nurses* (Regulation R.683, as amended) (SANC, 2006), define accompaniment as a “conscious and purposeful guidance and support for the student, based on her unique needs, by creating learning opportunities ... This process of accompaniment in conjunction with the direct involvement and physical presence of a tutor”. It is thus significant that nurse educators see their role as extending beyond the classroom and simulation rooms into the clinical placements of their students.

The respondents did observe the passive involvement of the nurse educators as such they stated that:

“They must be with us all the time, so that we can be serious of what we are doing, because if they are not next to us, some of us are not really serious”.

4.3.2.1.5 *Some nurse educators are not clinically competent*

Nurse educators are expected to be clinically competent as they serve as role models for the students.

“The tutor should have knowledge and skills, she must not only have knowledge, she must not only give lecture, she must have the skills of teaching students ... Some are having the knowledge while they are weak in giving the practical part”.

Nurse educators should act as role models to the students, in order that the students can be motivated to strive to be clinically proficient with the necessary knowledge and attitudes. According to the SANC Philosophy, a learning process that the learner should be involved in must be directed to ensuring personal and professional development, where analytical, critical and creative thinking, independent judgment and interpretation of scientific data are nurtured in the student (SANC, 1997:7). The SANC Philosophy (SANC, 1997:7) also states that:

[A] Learning experience occurs in the learning environment created by the person presenting the learning material and is utilised by the student to achieve objectives. These include, for example, clinical practica, clinical teaching, lectures, projects, etc with accompaniment.

Facilitation of learning therefore requires that the nurse educator remains clinically competent, and by so doing the nurse educator shall identify with the norms, standards and values of the profession and role model them to the students. Facilitation also includes assessment of the students. The nurse educator will not be able to assess the learners accurately if there is competency lack on her side. Mellish et al. (2000:220) indicate that an assessor for clinical practice should have the following capabilities:

- “Must be proficient herself
- Must be able to assess objectively
- Must have an appreciation for what can reasonably be expected from the student being assessed
- Must have the ability to get the best out of the students

- Must be able to assess objectively
- Must be unbiased in her judgments”

The respondents, having identified this lack of competency from some of the nurse educators, reflected upon the experience thus:

“... So, according to me, I think doing the accompaniment, they must clearly show us what we must do during accompaniment, because we are just about to be professional nurses, they must teach us so that we can accompany our students in the near future”.

4.3.3.1 Theme: Students’ challenges in relation to lack of equipment

Table 4.5 Students’ challenges in relation to lack of equipment

Category	Theme	Subtheme
4.3.3 Lack of equipment	4.3.3.1 Students’ challenges in relation to lack of equipment	4.3.3.1.1 Lack of equipment impacted on learning of clinical skills
		4.3.3.3.2 The problem of lack of equipment not attended to
		4.3.3.3.3 Lack of equipment impacted on placements of students in some units

The respondents complained of lack of equipment in all the units, there were only two students who did not complain of lack of equipment.

4.3.3.1.1 Lack of equipment impacted on learning of clinical skills

Lack of equipment led to the students not practicing the clinical skills, thus rendering them not proficient.

“The nursing procedures are done, but, most of the procedures we do not know them because we do not have the necessary... the necessary tools, the necessary tools to do the procedures, to can attend to those procedures well”.
“... I can give an example of, the ... Eh ... In theatre, sometimes we find that there are some operations which they do not do, we just hear about the operations, but we do not see them”.

“No, there are no equipments in this institution; we lack many types of equipment”.

For accompaniment to be conducted equipment is needed for either demonstration to the students or when assessing the proficiency of a student. Above all, the availability of all necessary equipment promotes quality nursing care. Mellish et al. (2000:218) indicate that the teaching programmes should be implemented with availability of material, according to different curricula and levels of training.

The SANC Philosophy indicates that, for the learning process to take place, there should be a clinical nursing laboratory for orientation of the students and a real-life situation in the units, with learning materials available to facilitate learning (SANC, 1992:5).

In all the units, the students were challenged by lack of equipment, which served as a setback for learning of clinical skills and quality patient care. Students expressed their challenges through the following narrations:

“The equipments are not enough because we are running short of some of the equipments, we just heard of them being mentioned, but we have never seen them at all”.

“We were also having problems with equipments, sometimes they were not in good working condition, but sometimes there were equipments ...”

“Hmmm ...eh.. about the equipments, we really have a great problem in our hospital, I don't know whether the reason is that it is the lowest level, but I think we still need equipments in order to equip ourselves scientifically in order to be able to approach different challenges that we come across with. I still think we still lack resources and when we used to go to different higher hospitals or institutions we meet so many different equipments ...”

4.3.3.1.2 *The problem of lack of equipment not attended to*

It appeared the problem of lack of equipment was not considered, as students complained though the institution trains students, besides even quality nursing care depends on availability of equipments.

“... but the management of the hospital should recommend that there are enough tools to can make use during the time of the procedures”.

“Hmmm there were equipments, even though not hundred percent. There were some shortages there and there, and you find that when there were no some of the equipments, it was disturbing nursing care ...”.

A training institution should have all the necessary equipment not only for the student to learn the clinical skills, but also to ensure that the patients/clients receive quality nursing care, so that the students can learn from nursing care executed, as role modelled by qualified staff. It is the responsibility of the management of the institution to ensure that all the necessary material resources are available (Mellish et al., 2000:98).

Though the problem did exist it was not attended to, because the students experienced this problem during their entire training. The respondents gave their concerns in the following narrations:

“Yes, the unit manager must go to the deputy manager nursing, but hierarchically to deal with it by maybe holding meetings in order to deal with the problem, for safety of the patients”.

“With me, I went to Mr ... the Pharmacist in charge. I once told him that we do not have a glucometer. He said to me I am having a glucometer, tell the unit managers to come and collect them, and really he provided us with the glucometers”.

4.3.3.1.3 *Lack of equipment impacted on the placements of the students in some units*

Because of lack of equipments students lacked experience in other clinical units.

"I can give an example of, theeh ... In theatre, sometimes we find that there are some operations which they do not do, we just hear about the operations, but we do not see them".

"... the problem was only the transport to take us to the clinic. We were sometimes having transport; sometimes we were not having transport but not enough for all of us. Some were remaining, and we were not going all together as a group".

The students are placed into the different units according to their curriculum and legal mandate, Regulation R.683 of 1989, as amended (SANC, 2006). Each unit has learning outcomes that should be achieved by the end of the placement. That calls for all the units where the students have been placed in to have the necessary equipment to assist in achieving of the learning outcomes.

In some units, there were no equipment, for example, in operating theatre some operations could not be done as such the student did not gain the learning experience in terms of preoperative, intraoperative and postoperative nursing care of some operations.

As the students were to be transported to the clinics for learning of clinical skills at the clinic, transport inconsistencies prevented the students to go to the clinics every day.

4.3.4.1 Theme: Students' challenges in relation to leadership role of management

Table 4.6 Students' challenges in relation to leadership role of management

Category	Theme	Subtheme
4.3.4 Lack of support from management	4.3.4.1 Students' challenges in relation to leadership role of management	4.3.4.1.1 Management does not ensure that units are fully equipped
		4.3.4.1.2 Management does not ensure that there are enough professional nurses and nurse educators
		4.3.4.1.3 No supervision role into teaching role of the unit manager and nurse educators
		4.3.4.1.4 No in-service education to empower the unit managers in their teaching role

Most of the students complained of lack of management into the smooth running of the institution, so as to ensure availability of material and human resources, and most importantly ensuring that accompaniment is conducted.

4.3.4.1.1 Management does not ensure that the units are fully equipped

A training institution need to have enough equipments so that the needs of patients can be met, students complained that management did not ensure availability of equipments.

"... but the management of the hospital should recommend that there are enough tools to can make use during the time of the procedures".

"I recommend that the institution must buy many types of equipment, to give us a chance to work freely to – to – to give the patients total nursing care ...".

The students need material resources for facilitation of learning. The nurse educators and unit managers also need material resources to enable them to conduct accompaniment. These material resources will facilitate acquiring of clinical skills, together with the necessary knowledge and appropriate attitude for execution of nursing care.

According to Quinn (2001:327), nursing education management should ensure the following based on quality assurance:

- That physical and learning resources support teaching and learning activities in all clinical units;
- Practice experience provides learners with learning opportunity so that they can achieve the stated learning outcomes;
- Programme management ensures that educational opportunities are implemented to enable the students to achieve the learning outcomes; and
- Students are supported so that they can achieve learning outcomes as stipulated in the educational programmes.

Other respondents expressed their concerns in the following narrations:

“Yes, the problem that we experienced is lack of equipments, and we told our tutors that we do not have equipments to practice”.

“Yes the unit manager must go to the deputy manager nursing, but hierarchically to deal with it by maybe holding meetings in order to deal with the problem ...”.

4.3.4.1.2 Management does not ensure that there are enough unit managers and nurse educators

A training institution need to have enough nurse educators and unit managers so that the learning units of the students can be taken care of, because of shortage of these facilitators of learning, students’ learning needs were compromised.

“I think the nursing - the unit managers should make it a point that they give us that support, but they cannot because they are insufficient, the allocation of the professional nurses in the clinical area is limited, let me say they are not enough”.

“Sometimes we were encountering problems because of the shortage of staff, we were.. Maybe the sister is busy and is alone in the ward, and did not get a chance to help us a lot”.

The management should see to it that the students get support from facilitators so as to ensure that learning outcomes are achieved, thus equipping the students with knowledge, skills and appropriate attitude for providing nursing care. The unit managers should be enough to can cope with their facilitation of learning responsibilities and patient care as well as other responsibilities the same applies to the nurse educators. Mellish et al. (2001:213) indicate that the nurse educators should also see their role extending from the classroom and demonstration rooms into the units for clinical teaching, and where the unit managers are also involved.

The respondents experienced shortage of both unit manager and nurse educators, and as such they expressed their frustrations in the following narrations:

“Hmm ... I think they should motivate for posts so that the staff could be a little bit enough...”

“... the tutors; they are very few they must be added”.

4.3.4.1.3 No supervision into the teaching role of the unit managers and nurse educators

The management of the institution has to ensure that there is smooth running of all units, including, problems expressed by the students, on the contrary the students had no one to rescue them.

“Okay I think when we are encountering problems we report our problems to the nurse educators, because we...according to us we are here because of them, but sometimes it is difficult for them to come down there and solve our problems, they usually refer us back to the same unit managers ...” .

“... and then I ... even though there were some lacks of skills here and there. And even the unit managers need to be developed in order to deliver the necessary skills to us their subordinates. So, I think is a lack of human development in our hospital that makes us the subordinates not gain the skills”.

It is also crucial that the facilitators are developed continuously and monitored to ensure that they work tirelessly to achieve the set objectives (Mellish et al., 2000:219).

The following narration depicts the experience of the student pertaining to lack of support of management into the problems encountered by them:

“In this accompaniment I should think there should be somebody who is allocated strictly to the students, who is always in the wards”.

4.3.4.1.4 No in service education to empower unit manager in their teaching role

Students felt that the unit manager need in service education to remind them of their teaching role, as the unit managers and registered nurses did not attend to their teaching role.

“Hmm I think there should be authority from above maybe, to make in service education in order for them to be courageous for the students, because it is for the benefit of us students ...”.

“The recommendation that I have is that maybe all the units have information in as far as training is concerned, I think there will be an improvement”.

Unit managers need ongoing in service education to conscientise them about their teaching role and support them so that they can be zealous in their teaching responsibilities (Mellish et al., 2000:274). Some professionals can be invited to guide the unit managers, or peer group teaching can be used so that the unit managers update each other on clinical teaching and the trends involved.

The respondents felt that the unit managers should be assisted to accept their teaching role, so that they (students) can benefit from their teaching including accompaniment. Their experiences that led them to state that unit managers would benefit from in service education are as follows:

“I think that the in service training can help if they can be called upon and discuss with them the problems we are encountering”.

“... and even the unit managers need to be developed in order to deliver the necessary skills to us the subordinates. So, I think just a lack of human development in our hospital that makes us the subordinates to gain not gain the skills.”

4.3.5.1 Theme: Students’ challenges in relation to doctors

Table 4.7 Students’ challenges in relation to the doctors

Category	Theme	Subtheme
4.3.5 Lack of support from the doctors	4.3.5.1 Students’ challenges in relation to doctors involvement in accompaniment	4.3.5.1.2 Some doctors do not support learning experience for student

One student indicated lack of support to one doctor; however, other doctors did provide support for the students. Some students indicated support from the doctors.

4.3.5.1.1 Some doctors do not support learning experience for students

The clinical facility should provide a learning opportunity and experience for the student. Doctors, as part of the team in the units, are also involved in accompaniment of the students, and should therefore support the students.

“... now that I’m in this ward, I’m having a problem with the doctor. The unit managers and our tutors used to say we must be advocates for our clients, with the doctor we are working with, when we suggest things he says he is the doctor you are a nurse, so he does not take them. So we do not know when this word advocacy works ... but this other doctor he does not want team work, when you take rounds with him you just provide him with what he wants”.

According to Quinn (2001:425), multidisciplinary approach and team work is important to provide learning opportunity for students. By so doing, the multidisciplinary team would have created an environment whose aim, according to Quinn (2001:425), would be "... to deliver quality care, to facilitate development of competencies, to provide teaching and learning opportunities ...".

Ward rounds play an important role in providing a learning opportunity for the students. Rounds, which can be a unit manager's rounds, a nursing service manager's or doctor's rounds, act as formal teaching for the students, as the students have to learn from the unit manager's demonstration (Mellish et al., 2000:158). The following skills can be learnt during the doctor's rounds:

- Assisting the doctor during physical examinations and diagnostic procedures
- Maintenance of the patients' privacy and dignity during such procedures
- Handling of verbal and written prescriptions, as well as handling telephonic prescriptions
- Handling reports and queries about doctor's notes in an effort to advocate for patients
- Assisting the doctor in giving information about the general condition of the patient, to indicate progress or poor progress

The learning experience helps the student to be aware of the role he/she should play during the doctor's rounds, and thus the student is afforded the necessary skills and will also need exposure to practice under the supervision of the unit manager (Mellish et al., 2000:159).

4.4 CONCLUSION

This chapter presented data analysis and interpretation, from which it was discovered that accompaniment experiences of the students did not satisfy their learning needs. The dissatisfaction of the students led to their frustration as they could not acquire the necessary skills. The importance of accompaniment cannot be overemphasised. It calls for role players in accompaniment to make some improvements, so as to ensure that accompaniment satisfies the learning needs of students.

CHAPTER 5

RESEARCH FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

This chapter presents the summary of findings, conclusions, recommendations made and the limitations of the study. In chapter 1, an introduction and overview of the study were outlined. Chapter 2 presented the supporting literature on clinical teaching and clinical accompaniment. This was followed by a detailed chapter 3 that discussed the research design and methodology of the study, which were as follows:

5.2 RESEARCH DESIGN AND METHOD

The researcher selected an explorative, descriptive, qualitative contextual research design (Mouton & Prozesky, 2005:7). The qualitative research design is a naturalistic investigation that lays emphasis on the understanding of human experience as it is lived, through careful collection and analysis of narrative and subjective qualitative materials (Polit & Beck, 2004:16). The researcher has interest in the interactive and subjective nature of this design as it allows participants to narrate their experiences; and thus facilitates an understanding of human beings in terms of their uniqueness, holistic nature and dynamic forces.

The accessible population for this study comprised of students registered for the bridging course for enrolled nurses (Regulation R.683 of 1989, as amended) in their final year of study, in the nursing school in the Sekhukhune District, Limpopo Province. In this study, a purposive random sampling of 16 students, registered for Bridging course for enrolled nurses leading to registration as a general nurse (Regulation R.683 of 1989, as amended), was conducted (SANC, 2006).

Data were collected through the semi-structured interview, with questions that guided the researcher to conduct the research. The study wished to answer the following research question: What are the student nurses' experiences of clinical accompaniment in the clinical setting? Chapter 4 discussed the data analysis using steps as described by De Vos et al. (2005:334) citing Creswell (1998:142).

5.3 RESEARCH FINDINGS AND INTERPRETATIONS

The research findings indicated that the students predominately experienced lack of support in terms of accompaniment, as reflected in many challenges they were faced with. Those challenges indicated that the students acquired minimal clinical skills instead of maximum clinical skills as an outcome expected by the SANC regulation (Regulation R.683 of 1989, as amended) (SANC, 2006).

From the data analysis made, the following findings were identified:

- Acquisition of clinical skills by the students were neglected by the institution
- Shortage of staff including registered nurses
- Students not afforded their student status, but were regarded as workforce
- Students lacked clinical learning experience for other clinical units, for example, the operating theatre and community (clinics)
- Patient care at high risk from incompetent students that are not supervised
- Producing of clinically incompetent registered nurses at the end of training
- Lack of leadership in overall supervision and monitoring of the education and training issues

The following is the summary of each the finding:

- **Acquisition of clinical skills by the students were neglected by the institution**

The study findings revealed that the unit managers and the nurse educators did not fully accomplish their accompaniment roles to ensure that students placed in the units are able to acquire appropriate clinical skills, knowledge and attitude. The SANC guidelines (Regulation Regulation R.683, as amended) expect the unit manager, as a registered

nurse, to facilitate the learning of a student, thus creating learning opportunity and directly assisting the student to optimise his/her learning outcomes. This is an escapable obligation as it is part of the scope of practice of registered nurse according to the SANC guidelines as per Regulation R.683, as amended. A registered nurse is expected to prescribe nursing care, and accompany students on how to apply the skills in providing the nursing care (SANC, 2006).

The same applies to the nurse educators; their role is not only confined to the classroom for theory. The SANC guidelines, with regard to the course *Bridging Course for Enrolled Nurses* (Regulation R.683, as amended), stipulate accompaniment as a “conscious and purposeful guidance and support for the student, based on her unique needs, by creating learning opportunities ... This process of accompaniment in conjunction with the direct involvement and physical presence of a tutor”. It is thus significant that nurse educators see their role as extending beyond the classroom and simulation rooms into the clinical placements of their students (SANC, 2006).

A study conducted by Murathi et al. (2005:13) investigated experiences of unit managers in terms of accompaniment. The findings revealed problems that have already been discovered by other researchers. For the first time, instead of preceptors mentioned, there was an involvement of unit managers in clinical teaching in planned programmes like seminars and workshops organised in the college, and an involvement of unit managers in formative and summative assessments.

- **Shortage of staff including registered nurses**

The shortage of staff impacted negatively on the training needs of the students. Enough staff should be a priority for training institutions, so that both patients and students can be attended to. Research by Mabuda (2008:4) cites Lita, Alberts, Van Dyk and Small (2000:30), and Moeti, Van Niekerk and Van Velden (2004:72) as indicating that workload and shortage of personnel impede accompaniment opportunities, and also indicating that shortage of equipment and supplies negatively affects the competency of newly-qualified registered nurses. Quinn (2001:187) cites Fish and Pur (1991) as having indicated in their study that supervisors were found to be having enormous workloads, with their roles not clearly defined.

These studies raised concerns related to lack of material resources and shortage of staff as a stumbling block for accompaniment, though this shortage was not clearly indicated whether it was from resources for the functional skill laboratory or the wards; and it was not also explicitly indicated whether the shortage of staff was from the educators or the clinical staff. If the issue of shortage of staff was not addressed problems of lack of accompaniment will not be resolved.

In the same manner, research conducted by Carlson et al. (2003:30) postulates that students' experiences reflected uncertainties due to lack of opportunities for them to acquire nursing skills. The contributing factors were identified as:

- Unavailability and inaccessibility of staff due to time and workload constraints
- Shortage of equipment to execute nursing care
- Lack of support and guidance in the clinical learning environment by those entrusted with a responsibility of supervision

The problem of workloads is perhaps related to shortage of staff as the workloads are usually increased by shortage of staff.

- **Students not afforded their student status but were regarded as workforce**

Students were not accompanied as they were regarded as the workforce. As a result of staff shortage, much concentration was put on patient care. Students are placed in the units for the purpose of learning, so that they cover their learning outcomes according to the skills to be learnt in that particular unit, and through the support of the Unit Manager accompanying them to the patients, they will be able to acquire those skills (Mellish et al., 2000:213). Lack of support frustrated the students and also put the safety of the patients at risk.

- **Students lacked clinical learning experience for other units, for example, operating theatre and community (clinics)**

The problem of lack of equipments disadvantaged the students, as in operating theatre most of the operations were not done because of lack of equipments. For clinical experience, there was no regular transport to convey the students to the clinics, so the clinic experience was minimised, and that became a major disadvantage for the students.

A training institution should have all the necessary equipments, not only for the student to learn the clinical skills, but also to ensure that the patients/clients receive quality nursing care, so that the students can learn from nursing care executed, as role modelled by qualified staff. It is the responsibility of the management of an institution to ensure that all the necessary material resources are available (Mellish et al., 2000:98).

- **Patient care at high risk from incompetent students that are not supervised**

Participants indicated that they have to run the units as the unit managers were not on duty, meaning the students were left alone. The problem of shortage put patient care under risk, as patients remained with students, no registered nurse coverage for the unit. A student practises nursing procedures under the direct and indirect supervision of the unit manager and other professional nurses allocated to the unit. Direct supervision occurs when the student is still learning to acquire the skill, and indirect supervision when the student has acquired the skill. According to Mellish et al. (2000:209), the unit manager must be present at all times to supervise the unit in terms of facilitation of learning and patient care, thus serving as a role model. Besides the absence of the registered nurses due to shortage, there are other reasons, such as having to attend meetings, and thus students being left alone.

- **Producing of clinically incompetent registered at the end of training**

The problem of lack of accompaniment affected the competency of students negatively leading to production of clinically incompetent registered nurses. Mellish et al. (2000:76) speak of a nurse educator in her role as a leader as a “referee, detective, a diffuser of anxiety, a target for hostile feelings and frustrations, friend and confidante and ego

supporter". If the nurse educator does not allocate enough time for accompaniment the roles will not be played. Similarly, the unit manager has a teaching role entrusted on his/her shoulders to ensure that students placed in the units are able to acquire appropriate clinical skills, knowledge and attitude. The SANC guidelines (Regulation R.683, as amended) expect the unit manager, as a registered nurse, to facilitate the learning of a student, thus creating learning opportunity and directly assisting the student to optimise his/her learning outcomes (SANC, 2006).

- **Lack of leadership in overall supervision and monitoring of the education and training issues**

The management did not monitor smooth running of education and training and endeavour to solve problems emerging. The leadership of the institution has to ensure that the education and training needs of the students are taken seriously throughout. Any problems identified must be explored and solved so that clinically competent nurses are produced at the end of their education and training that are ready to serve humanity.

The management must see to it that the students get support from facilitators so as to ensure that learning outcomes are achieved, thus equipping the students with knowledge, skills and appropriate attitude for providing nursing care. The unit managers should be enough to can cope with their facilitation of learning responsibilities and patient care as well as other responsibilities the same applies to the nurse educators. Mellish et al. (2000:213) indicate that the nurse educators should also see their role extending from the classroom and demonstration rooms into the units for clinical teaching, and where the unit managers are also involved.

5.4 SUMMARY OF THE FINDINGS

The research results indicated that the students predominately experienced lack of support in terms of accompaniment, as reflected in many challenges they were faced with. Those challenges might indicate that the students acquired minimal clinical skills instead of maximum clinical skills as an outcome expected by the SANC regulation, which controls their training (Regulation R.683 of 1989, as amended). When the guidelines of the regulation is followed, Regulation R.683 of 1989, as amended, the nurses produced at the

end of training would be clinically skilled, and ready to apply nursing care to patients/clients with professional excellence, dignity and confidence (SANC, 2006). Lack of competency of the students will result in far reaching consequences, which includes poor nursing care and failure to accompany the future generation of students.

The research results point to the institution to improve on this crucial matter, so as to ensure that future students will be clinically competent through accompaniment and serve humanity with expertise and dignity.

5.5 RECOMMENDATIONS

Recommendations are made in terms of practice, education, management and further research.

5.5.1 Recommendations to practice

After considering clinical practice as one of the most important facets of the educational preparation of nursing students, the following recommendations were made:

- Development of clinical placements model for practice
- Quality assurance system to monitor education and training

5.5.1.1 *Development of clinical placements model for practice*

The model will clearly indicate the following:

- The responsibility of the service personnel in terms of accompaniment of the students
- Student support that explain how learning needs and learning opportunities are created, and how supervision is sustained
- Clearly defined roles and responsibility for unit clinical practitioners or registered nurses including multidisciplinary team members, preceptor (practice educator) mentor, unit managers, the link lecturer and the student

- Formalised system of communication and feedback between the practice and education personnel to solve any problems
(Andrews & Andrews, 2006:870)

5.5.1.2 *Quality assurance system to monitor education and training*

- Provision of constructive feedback and evaluation of students ensures effectiveness of clinical placements, and offer frequent encouragement, opportunities for reflection and provides confidence and support on the part of the student. Andrews and Andrews (2006:871) cite Löfmark and Wikblad (2001) as indicating that feedback and opportunities to reflect obstruct learning when absent.
- Students' feedback regarding the overall clinical placements learning environment is important as it contributes to the ongoing evaluation of the clinical learning environment, and, as such, maximises learning.
- Feedback of clinical placements and learning opportunities available to students as audits must be completed by the link lecturer, the preceptor and mentors periodically.
- To evaluate effectiveness of learning in clinical placements.

5.5.2 Recommendations for education

- Accompaniment of students in the clinical setting is a shared commitment and joined guidance by the academic and clinical setting personnel
- Lecturers roles should be clearly defined in terms of accompaniment, as well as programmes for accompaniment
- Link lecturers that serve as the link between the education and clinical practice should also have their roles clearly defined

5.5.3 Recommendations for management

- The role of management is to ensure that a budget exists to fully equip all units so that learning opportunities for students can be created
- Recruitment of staff is very crucial to ensure that students will be provided with accompaniment as expected

- Use of link lecturers, preceptors and mentors is very crucial to ensure smooth running of training of students
- Encouraging of multidisciplinary team members to be involved in clinical teaching will be beneficial to the students
- Supporting the clinical practitioners and nurse educators with workshops and courses to ensure that up to date trends and methods are used
- Development of standards and policies for quality accompaniment
- Use of quality assurance system to ensure that accompaniment is conducted within standards set
- Overall supervision of education and training to ensure that accompaniment is done

5.5.4 Recommendation for further research

Further research needs to be conducted in a broader scope in the training hospitals of the province, Limpopo, as the current study was limited to one hospital. In order that the problem can be successfully addressed, research needs to be conducted on the experiences of unit managers in terms of accompaniment.

5.6 CONTRIBUTIONS OF THE STUDY

The study contributed in considering the acquisition of clinical skills, knowledge and values by students as important through accompaniment, so as to ensure a generation of competent nurses. The role players involved in accompaniment were made aware of the important roles they have to play in accompaniment of students. Recommendations made will serve as guidelines to improve accompaniment for the students. Quality patient care would be enhanced, as improvement in accompaniment will result in the production of competent nurses. Quality patient care would mean improved image of nursing as a profession, and excellent nursing care for the community with reduced or no lawsuits. Students will enjoy training in the institution and there will be no attrition on the part of the students.

5.7 LIMITATIONS OF THE STUDY

The study was confined to one institution, as such the findings cannot be generalised to other institutions. The sample consisted of the students only. The inclusion of accompanist in the clinical setting in the clinical area could have enhanced perspectives and their view on the students conduct. A follow-up study to be conducted in other Limpopo institutions in order to identify similarities or differences in terms of experiences during accompaniment is necessary.

5.8 CONCLUSION

The findings of this research indicated that students struggled to meet their learning needs, as accompaniment is not conducted efficiently in order to support students. The students' experience of frustration not only lead to incomplete acquisition of clinical skills, but would also impact on service delivery. It is therefore imperative that guidelines be developed to ensure that role players involved participate according to the guidelines, so that clinically competent nurses can be produced.

Accompaniment of students is crucial for the achievement of the desired high standard of care. If no effort is put into accompaniment as a learning opportunity for the students, frustrations of the students will always emerge with concomitant poor nursing care of our communities, hence goes the saying, one shall reap what one has sown. All the facilitators need to play their roles and give the students the necessary support they deserve. The use of the above-stated recommendations can enhance the training of the students, so that the students become proficient, and execute quality nursing care with pride, confidence and expertise.

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ANNEXURE A

Letter requesting permission to conduct the study

ANNEXURE B

Letter obtaining permission to conduct the study

ANNEXURE C

Consent from student participants

ANNEXURE D

Interview protocol

ANNEXURE E

Example of a portion of transcribed data