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CLINICAL FACILITATION: UNDERGRADUATE NURSES' PERCEPTIONS OF BEST PRACTICE IN AN ACADEMIC HOSPITAL IN JOHANNESBURG

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Science in Nursing.

Johannesburg, 2015

DECLARATION

I, Immaculate Sabelile Tenza, declare that this dissertation is my own work and that all the sources quoted have been indicated and acknowledged by means of complete references and is being submitted for the degree of Master of Science in Nursing Education. This report has not been submitted for any other degree at any other institution.

Signature: ……..…… on this ……day of ……2015

Immaculate Sabelile Tenza

DEDICATION

In dedication to my Lord and Saviour, Jesus Christ,

The King of Kings,

The Prince of Peace

Ingonyama Yomndeni KaJuda

Ebenezeri

ABSTRACT

Introduction and Background

Clinical teaching is considered as an essential and very important part of the undergraduate nursing curriculum, as it allows nursing students to apply the theoretical knowledge they learn in the classroom and transfer it into real life situations. According to the new model of Clinical Nursing Education and Training in South Africa, clinical teaching should make up 70% of the undergraduate nursing curriculum. Nursing students spend their time in the clinical practicum learning the skills and values of the nursing profession, with the goal of achieving the clinical learning outcomes as prescribed by their nursing education institution and the South African Nursing Council. During this time, nursing students depend on clinical facilitators to facilitate their clinical learning in order for them to meet their objectives effectively.

Purpose of the study

The aim of this study was to explore and describe the perceptions of undergraduate nursing students, regarding the best practice of clinical facilitation of their learning, in their clinical practicum.

Research methods

A qualitative, descriptive and exploratory study was conducted. It explored the views of the undergraduate nursing students regarding best practice clinical facilitation of their learning in an academic hospital. Three focus groups were conducted consisting of 24 participants in total. The interview question was: **As student nurses what do you think constitutes best practice**

in your clinical practicum experience with regard to clinical facilitation? Field notes were written and data was analysed using Creswell's qualitative data analysis method.

Main Findings

Three main themes emerged with 13 subthemes and a thick, dense description of the results is presented. Undergraduate nurses' perceptions of best practice in clinical facilitation were identified relating to *facilitation of clinical learning in the nursing skills laboratory* and *facilitation of clinical learning in the patient care areas*, including *the methods of learning such as preceptorship, questioning, nursing rounds and inter-professional discussion*.

Pre-contact preparation of nursing students for simulation of procedures, use of teaching aids and grouping students into smaller groups during skills demonstrations were all identified as best practices for clinical learning in the nursing skills laboratory. Standardisation of procedures between the university and the clinical practice areas and availability of nurse educators from the university to support the nursing students in the clinical areas were identified as facilitating factors for clinical learning in the patient care areas. Implications of these results are discussed and recommendations provided to promote best practice clinical facilitation of student learning in their clinical practicum.

Conclusion

In order to achieve best practice clinical facilitation of undergraduate clinical learning, certain measures must be put in place in both simulation and patient care areas. There is a need to ensure effective pre-contact planning of clinical training sessions, including teaching methods and ensuring small group learning. The findings advocate the need for nurse educators to be closely involved in clinical accompaniment to assist in theory–practice integration. It was also

revealed that a collaborative effort towards clinical teaching is necessary from all categories of clinical facilitators in order to achieve best practice clinical facilitation of undergraduate students.

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CHAPTER ONE

OVERVIEW OF THE STUDY

1.0 INTRODUCTION

Chapter One gives an overview to this study. The background to the study, problem statement, research question, purpose of the study, research objectives, significance of the study as well as the research design and method are outlined in this overview. A brief overview of data collection and data analysis has also been included. The principles used to ensure trustworthiness and ethical considerations are outlined.

1.1 BACKGROUND TO THE STUDY

Nursing is a practice-based profession and the importance of clinical teaching in nursing education cannot be over-emphasised. Gaberson and Oermann (2010:8) state that clinical teaching is the most important component of nursing education, more so than classroom teaching (Gaberson and Oermann, 2010:8) and is therefore regarded as an integral part of the undergraduate nursing curriculum. According to the proposed model of clinical education and training in South Africa, clinical teaching must make up 70% of the undergraduate nursing curriculum (Nursing Education Stakeholders Group, 2012:5). Mabuda, Potgieter and Alberts (2008:19) state that clinical teaching aims to assist student nurses to learn to apply the theory of nursing in real life situations and facilitation of learning in the clinical practice helps students to integrate theoretical knowledge and practical skills. Ensuring best practice in facilitation of clinical learning is vital in nursing education as it is through this that the student learns the skills and values of the nursing profession.

In South Africa, nursing students are required to undergo a four year fulltime degree or diploma programme in order to qualify as a professional nurse. During this training programme, a minimum of 4000 hours of supervised experience in clinical practicum is mandated (South African Nursing Council Regulations No.R425). Nursing students rely on the clinical facilitator's teaching to maximise the time spent in the clinical area to learn and perfect the art and skill of nursing, as well as to comply with the South Africa Nursing Council requirements of clinical learning. The aim of professional nurse education and training is to enable the learner to function as a clinically competent, service oriented, independent nurse practitioner, who is able to render nursing care across all spheres of health (South African Nursing Council regulations No.R425, 1988).

The Nursing Education Institution (NEI), at which the student nurse is registered for training, is responsible for the submission of the evidence of the student's competence of theoretical and clinical learning. This has to be submitted to the South African Nursing Council (SANC) on completion of the student's training in order for the learner to be registered as a professional nurse. As an employee of the NEI, it is the responsibility of the nurse educator to ensure that the nursing student achieves these requirements.

In the nursing education institution where this research was conducted, undergraduate nursing student's clinical teaching occurred in the nursing skills laboratory and in the clinical learning area. With regard to general nursing skills, there was one clinical instructor from the university who was paired with a nurse educator for accompaniment of the students in the first and second years. The nurse educator class or course teachers for third and fourth year nursing students accompanied their own students. In 2014, when this study was conducted, there were 48 first year nursing students, 29 second year, 14 third year and 17 fourth year students

Second year students were placed in the clinical facility for six hours per week and the third years were placed in the clinical facility for one full day (twelve hours) per week. Second years also attended demonstration and practice of nursing procedures in the Nursing Skills Laboratory, for three hours every Thursday, in the presence of their clinical instructors and nurse educators from the nursing education institution. Demonstration of basic nursing skills was done in the Nursing Skills Laboratory prior to placement in the clinical facility. Fourth year students attended classes in a block system, whereby they attended classes for a whole week and then returned to the clinical area to continue their practica for some time before returning for another theory block.

The academic hospital where this research was done was a clinical facility where the students from this nursing education institution were placed for their clinical practicum. In this academic hospital, the clinical facilitators for each department and registered nurses were expected to teach the nursing students during their placement in the clinical facility. A number of Nursing Education Institutions (NEIs) placed their students for learning in this academic hospital and the registered nurses and the clinical instructors who were employed by this clinical placement facility were responsible for the clinical teaching of any student nurse placed in the facility. Nurse educators who placed the students were also expected to do clinical visits for teaching of their students during their clinical practicum.

Whilst the researcher worked in an academic hospital, it came to her attention that both undergraduate and post-graduate nursing students often verbalised dissatisfaction regarding the clinical facilitation of their learning. The researcher views the undergraduate nursing students as adult learners. Adult learners are characterised by their ability to take responsibility for their own learning and are able to identify their own learning needs and their views are important on

planning their learning (Quinn and Hughes, 2007:29). The researcher believes that as the undergraduate nursing students take responsibility of their own learning, they are able to judge which course of actions by clinical facilitators lead to effective clinical facilitation of their learning. When viewing an undergraduate nursing student as a client of the clinical teaching service, the researcher believes it is vital to know their views of what they perceive as best practice in clinical facilitation of their learning, as this could influence the improvement of the quality of clinical teaching and learning. Armstrong (2013:146) asserts that when implementing quality improvement based on client focus principle, the client is the main evaluator of what is best for them.

An assessment of students learning preferences and perception of best practices is a diagnostic tool that can assist an educator to better understand students. This idea is supported by Xiao (2006:13), who states that educators should assess learner's needs and preferences instead of depending on intuition when planning teaching methods, hence there is a need to enquire about nursing student's perceptions of best practice with regard to clinical facilitation.

Therefore, nursing students are a good resource when one is looking for understanding best practice of clinical facilitation as viewed by the receiver of the facilitation. With this in mind, a student-centered approach to nursing education is highly desirable and if this is to be successfully applied, it is necessary to understand the student's viewpoint on best practice of facilitating clinical learning.

1.2 PROBLEM STATEMENT

A student-centered teaching approach, with emphasis on facilitated learning rather than giving information to the students (Chiang, Chapman and Elder, 2010:816), is highly

desirable in nursing, but if such an approach is to be successfully implemented, students' perceptions of best practice need to be considered. Little is known about what the undergraduate nursing students believe to be best practice regarding facilitation of their clinical learning in an academic hospital.

1.3 RESEARCH QUESTION

What do undergraduate nurses believe is best practice with regard to clinical facilitation?

1.4 RESEARCH PURPOSE

To explore and describe the perceptions of undergraduate nursing students, regarding the best practice of clinical facilitation of their learning in their clinical practicum.

1.5 RESEARCH OBJECTIVE

To determine what type of clinical facilitation undergraduate students believe should be offered by clinical facilitators in the clinical area in order to best facilitate their learning.

1.6 SIGNIFICANCE OF THE STUDY

The findings of this study will add knowledge to the nursing profession with regard to understanding nursing student's perceptions of best practice facilitation of their clinical learning. The findings of this study will then be able to guide educators and clinical instructors as to how best to enhance clinical teaching in the undergraduate student's clinical practicum.

1.7 DEFINITION OF KEY CONCEPTS

- **Perceptions** are ideas, beliefs or images that a person has as a result of how he sees or understands something (Oxford Advanced Learner's Dictionary, 2013).
- **Best Practice** is the best and the most effective way to do something. “It may also be a working method or set of working methods that are noted as the best to use in a particular business or industry.” (Cambridge Advanced Learner’s Dictionary, 2014).
- **Nursing students**. According to this study, nursing student refers to an individual who is registered for full time study in a four year academic programme, with a selected nursing education institution and with the South African Nursing Council and is studying towards the attainment of the Degree in Nursing (General, Community, Psychiatry) and Midwifery.
- **Clinical practicum** is a clinical environment where students can learn and develop clinical nursing skills in a real life situation, under the guidance of an experienced professional (Bruce, Klopper and Mellish, 2011:255).
- **Clinical facility** is a health care environment where the primary purpose is patient care and the facility is also used for teaching nursing students (South African Nursing Council, Government Regulations No.R174, 2013:2).
- **Clinical Placement.** Placement refers to the act of placing someone in a work place for the purpose of gaining work experience (Concise Oxford Dictionary, 2008:1094). Clinical placement is placing nursing students in a clinical practicum for the purpose of learning.

- **Nursing Skills Laboratory.** In this study, this refers to the simulation room in a nursing education institution where nursing skills are demonstrated and practiced in a relatively safe environment.
- **Facilitation of Learning** means helping students, individually or in groups, to work effectively to achieve the learning outcomes. It involves the interaction between a student and a facilitator which result in a student being guided to new meanings and understandings (Bruce, Klopper and Mellish, and 2011:112).
- **Clinical Facilitation** is the process of helping and guiding students individually or in groups to work effectively to achieve their learning outcomes in their clinical practicum; it involves planning activities which may stimulate and support their learning.
- **Clinical teaching** is an act of designing appropriate learning activities which enhance student learning in the clinical practicum, the clinical teacher guides, supports, stimulates and facilitates learning (Gaberson and Oermann, 2010:6).
- **Clinical accompaniment** is a structured guidance and support of the nursing students based on their unique learning needs (Bruce, Klopper and Mellish, 2011: 254). This structured process of supporting nursing students in their clinical practicum is done by nurse educators to ensure the students achieve their learning outcomes (South African Nursing Council Regulations, Government Regulations No.R.174, 2013:1).
- **Clinical Instruction** is an alternative term for clinical facilitation. Clinical instructor, refers to a professional nurse who is employed by either a nursing education institution or a clinical facility for the purpose of clinical teaching of

nursing students (Bruce et al. 2011:257); also known as a clinical preceptor (Nursing Education Stakeholders Group, 2012: 2).

- **Clinical supervision** means "The assistance and support extended to the learner by the professional nurse at a clinical facility, with the aim of developing a competent, independent practitioner" (South African Nursing Council, government regulations No.R.174, 2013:2).
- A **clinical supervisor** is a professional nurse working in a clinical setting who supports and develops nurses in the unit team to enhance their professional functioning and is employed by the clinical facility; is mostly known as clinical facilitator (Nursing Education Stakeholders group, 2012:2).
- **Registered nurse** is a person who has the qualification and competency to independently practice comprehensive nursing ensuring responsibility and accountability for her practice and is registered with the Nursing Council as a professional nurse (Nursing act 2005:25).
- **Nurse educator** is a registered professional nurse with an additional qualification in nursing education and is registered as such with the South African Nursing Council (South African Nursing Council, competencies for nurse educators, 2014:3). In this study nurse educators refer to those who are working as lecturers in a nursing education institution.
- A **student centered teaching approach** is an approach to teaching whereby there is high emphasis on facilitation of learning taking consideration student's previous experiences that they bring to the learning situation, their learning needs as well as their preferred learning methods (Young & Paterson, 2007:5).

Conceptual Definitions

- **Best Practice** in this study, will refer to the actions and ideas which represent the most efficient, effective or prudent course of action.
- **Clinical facilitators** in this study, refer to all Preceptors, Clinical instructors, Clinical supervisors and Registered nurses who facilitate learning of the undergraduate nursing students in the clinical practicum.

1.8 OVERVIEW OF RESEARCH DESIGN AND RESEARCH METHOD

The research design applied in this study is qualitative, explorative and descriptive in design. In this study, perceptions of undergraduate nursing students on best practice in clinical facilitation of their learning were investigated.

The site chosen for this study was a pre-selected nursing education institution and an academic hospital in Johannesburg, where student nurses studying for the degree in nursing for registration as a professional nurse are placed for their clinical practicum.

The population was all the nursing students studying for an undergraduate degree leading to registration as a Nurse (General, Community and Psychiatric) and Midwife at the preselected academic hospital in Gauteng Province of South Africa.

Purposive sampling of second, third and fourth year undergraduate nursing students was done. These students were presumed to have adjusted to the clinical learning environment and therefore would be able to give insight into their perceptions of

best practice. Semi-structured focus group interviews were conducted using an interview guide; saturation was reached after completing a total of three focus group interviews. All interviews were recorded verbatim and field notes were written. Creswell's (2009:184) method of qualitative data analysis was used and thick, dense description of findings were presented in themes and subthemes.

Lincoln and Guba's (Polit and Beck, 2004:430) criteria of measuring trustworthiness was applied to ensure rigour of the study. Permission for conducting the study was sought from the University of the Witwatersrand Human Research Ethics Committee (Medical), the Postgraduate Research Committee and the Head of Nursing department of the University of the Witwatersrand. Voluntary consent for participation and for digital recording was sought from all the participants.

1.9 CONCLUSION

In this Chapter, the background of this study, the problem statement, research question, purpose and objectives were explained. Operational definitions were supplied and research design and method were briefly covered and will be explained in detail in Chapter Three.

The following chapters are to follow:

Chapter Two provides a literature review.

Chapter Three discusses methodology.

Chapter Four covers presentation of the findings.

Chapter Five gives discussion of the findings, the conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This chapter presents the literature review surrounding clinical teaching of undergraduate nursing students in the clinical practicum. Issues covered in this literature review are as follows: significance of clinical teaching in undergraduate nursing curriculum, approaches used to achieve clinical teaching of undergraduate nursing students such as clinical accompaniment, clinical instruction, preceptorship, clinical supervision (all referred to as clinical facilitation in this research), the role of South African Nursing Council to regulate and monitor quality in clinical nursing education and training, realities of clinical facilitation situation in South Africa and clinical facilitation modalities used in other countries and their challenges.

2.1 SIGNIFICANCE OF CLINICAL TEACHING IN UNDERGRADUATE NURSING CURRICULUM

According to Gaberson and Oermann (2010:6), clinical teaching is an act of designing appropriate learning activities which enhance the learning of nursing students during their clinical practicum. This is done through guiding, supporting, stimulating and facilitating the students learning.

The literature on clinical nursing education supports nursing student's learning in the clinical practice as an essential part of nursing education training worldwide, being described as fundamental and the core of undergraduate nursing education curriculum (Ali,2012:15; Elcigil and Sari, 2011:67; Price, Hastie, Duffy, Ness and McCallum, 2011:780). Nursing students learn

to apply the knowledge they acquired in the classroom, as they learn by doing in their clinical practice (Okoronkwo, Onyia-Pat, Agbo, Okpala and Ndu, 2013:63).

Henderson, Heel and Twentyman (2007:92) state that clinical teaching provides nursing students with the opportunity to develop technical competency and problem solving skills. Effective clinical teaching is essential to produce knowledgeable and skillful nurse practitioners, with confidence and active involvement in a multi-disciplinary team (Okoronkwo, Onyia-Pat, Agbo, Okpala and Ndu, 2013:63).

2.2 APPROACHES USED TO ACHIEVE EFFECTIVE CLINICAL TEACHING OF THE UNDERGRADUATE NURSING STUDENTS

Various methods are used by nursing education institutions and clinical facilities to achieve effective clinical facilitation of the nursing students, namely clinical accompaniment, clinical instruction, clinical facilitation, clinical supervision and preceptorship. Different terms are used in different literature and in practice areas, often referring to the same terminology.

Clinical facilitation and clinical instruction are terms used to describe the facilitation of learning in the clinical placement area and refers to the assisting of students individually or in groups to work effectively to achieve their learning outcomes. Clinical facilitation includes the interaction of facilitators with students to draw out their thoughts and guide them to new understanding during their clinical practicum (Bruce, Klopper and Mellish, 2011:112).

Clinical supervision is an integral part of clinical facilitation as it provides “the assistance and support extended to the learner by the professional nurse at a clinical facility with the aim of developing a competent, independent practitioner” (SANC Regulations, Government Notice no.R174, 2013:2).

Clinical accompaniment is also an important part of students' development in their clinical practicum. Clinical accompaniment is described as a structured guidance and support of the nursing students based on their unique learning needs (Bruce et al, 2011: 254). Clinical accompaniment is done by nurse educators to ensure students achieve their learning outcomes (SANC Regulations, Government Notice no.R174, 2013:1)

Literature describes a clinical instructor, or clinical preceptor, as a professional nurse who is employed by either a nursing education institution or a clinical facility for the purpose of clinical teaching of nursing students (Bruce et al, 2011:257; Nursing Education Stakeholders Group, 2012:2).

2.3 THE ROLE OF THE SOUTH AFRICAN NURSING COUNCIL TO REGULATE AND MONITOR QUALITY IN CLINICAL NURSING EDUCATION

In South Africa, the South African Nursing Council (SANC) is a statutory body which regulates the training of nurses and is responsible for monitoring the quality of nursing education and training. The South African Nursing Council is also responsible for the accreditation of the nursing education institutions, nursing programmes and the clinical practice areas where students will be placed for such training, (Nursing Act No.33 of 2005, 2005:8).

For accreditation by SANC, the South African Nursing Council (SANC Regulations, Government Notice no. R173, 2013: 5) requires the nursing education institution to have a formal agreement with relevant authorities for clinical placement areas as a training site. The training facility must provide learning opportunities, which will meet the needs of learners placed in these clinical practice areas through clinical accompaniment and supervision (SANC Regulation no.R173, 2013:5). The clinical placement facility, which is accredited with SANC,

also appoints the clinical facilitators to teach the staff and the students who are placed in that facility.

2.4 REALITIES OF THE CLINICAL FACILITATION SITUATION IN SOUTH AFRICA

Whilst all the regulations discussed in the previous paragraphs are in place, the reality is achieving effective clinical facilitation of undergraduate nursing student's clinical learning remains an ongoing challenge in the country. Rikhotso, Williams and De Wet (2014:1) state there are still uncertainties in South Africa with regard to whose responsibility it is to facilitate learning in the clinical practicum and there is often a shift of this role between nurse educators and registered nurses.

Bruce et al (2011:256) assert that every registered nurse has a responsibility and accountability for the quality of care given to the patient and as a result registered nurses have a moral duty to teach, mentor and supervise nursing students to be sure they can deliver quality care to the patients and ensure patient safety.

Bruce et al (2011:256) further assert that clinical teaching is the responsibility of the professional nurse and the unit manager employed by either the nursing education institution or by the health care facility for clinical teaching purposes where students are placed for learning purposes.

According to the South African Nursing Council's Competencies of Nurse Educators (SANC, Competencies for Nurse Educator, 2014:3), nurse educators must facilitate learning of the nursing students and ensure the development of cognitive, psychomotor and affective skills which can only be developed through effective clinical facilitation. Elliot and Wall (2008:582)

believe it is the role of nurse educators to ensure they are preparing the students for the realities of clinical work and that this can be better achieved if educators are actively involved in clinical practice in order to be in touch with current clinical practices.

A study done on perceptions regarding clinical accompaniment of student nurses in the Limpopo Province of South Africa, revealed that the majority of nurse educator's perceived clinical accompaniment not to be their task (Lekhuleni, Van der Wal and Ehlers, 2004:15). This perception contradicts the expectations of the South African Nursing Council. This issue, of clinical teaching is also described in a study done by Mabuda, Potgieter and Alberts (2008:22), who found that nurse educators were not accompanying nursing students, who were consequently left to rely on the ward registered nurses for clinical teaching and who, in turn, were not able to teach students due to shortage of staff and increased workloads.

According to the new model of nursing education and training in South Africa, the nurse educators will take full responsibility for the quality of clinical learning of the nursing students and will be expected to be actively involved in preceptorship of nursing students during their clinical practicum (Nursing Education Stakeholders Group, 2012:4).

It is the researcher's experience that nursing students in an academic hospital, both undergraduate and post graduate level students, often verbalised their dissatisfaction regarding clinical facilitation during their clinical placement. Some of the usual remarks of dissatisfaction were confirmed in the study by Volschenk and Van Heerden (2009:7) on student's experiences of their clinical learning experience in a private hospital in South Africa, where it was found that students often complained about being treated like an additional pair of hands to cover shortages, which did not allow them to complete their clinical learning outcomes.

Supporting the existence of the challenges towards achieving effective clinical facilitation is the strategic plan for nursing education, training and practice (The Strategic Plan for Nursing Education, Training and Practice, 2013:21-22) which reports that there is inadequate clinical facilitation of nursing students in the majority of clinical facilities in the country as a result the newly qualified nurses become inadequately prepared for their roles.

2.5 CLINICAL FACILITATION APPROACHES USED IN OTHER COUNTRIES

In Australia, clinical facilitation of undergraduate nursing students is achieved through preceptorship, clinical instruction and a combined method where nurse educators, clinical instructors and clinical preceptors play a role in clinical teaching of undergraduate nursing student (Franklin, 2013:39). Franklin (2013:40) asserts that it remains indistinct which method is the best on achieving effective clinical teaching of undergraduate nursing students in Australia, however, clinical instruction and the use of nursing educators to accompany nursing students remains preferred as it relieves registered nurses from their challenging dual role of both patient care and teaching. In Canada, facilitation of clinical learning is mostly achieved through preceptorship and, as a result, clinical teaching of nursing students depends on the willingness and the availability of registered nurses to do clinical teaching (Sedgwick and Harris, 2012:1). This is a result of a shortage of nurse educators with clinical expertise to enable them to supervise nursing students in the clinical practice (Sedgwick and Harris, 2012:1). Shortage of nursing staff coupled with the overcrowding of nursing students in the limited placement areas negatively affects the registered nurse's availability for their teaching role (Sedgwick and Harris 2012:3).

Literature reveals the significance of implementing effective measures on clinical facilitation of nursing student's clinical learning in order to produce competent and skilled professional

nurse graduates. Dissatisfaction and inadequacy of clinical facilitation of undergraduate nurses in South Africa has been reported in literature. The research question emerged: What do undergraduate nurses believe is best practice with regard to clinical facilitation? In this study, the researcher hoped to determine what type of clinical facilitation undergraduate students believe should be offered by clinical facilitators in the clinical area in order to best facilitate their learning.

2.6 CONCLUSION

In this chapter, literature surrounding clinical teaching has been explored. The next chapter will discuss the research methodology used in this study.

CHAPTER THREE

RESEARCH DESIGN AND RESEARCH METHOD

3.0. INTRODUCTION

In this chapter, the research design, setting, population, sampling and method used for data collection and data analysis are discussed, as well as the measures to ensure ethical compliance and trustworthiness of the study.

3.1 RESEARCH DESIGN

Research design is defined by Polit, Beck and Hungler (2001:470) as "the overall plan for addressing a research question, including specifications for enhancing the study's integrity." Fouche (2005:268-269) defines research design as the approach or method chosen by a researcher to study the phenomenon based on its suitability to achieve the objectives of the study.

The research question being addressed in this study was: **What do undergraduate nurses believe is best practice with regard to clinical facilitation?**

The objective was to determine what type of clinical facilitation undergraduate students believe should be offered by clinical facilitators, in the clinical area, to best facilitate their learning. The researcher deemed a qualitative, explorative, descriptive and contextual design to be the best research design to achieve this objective. The reasons for the chosen research methods are described below.

3.1.1 **Qualitative research**

According to Brink (2008:113), qualitative research is a method of enquiry which focuses on the in-depth aspects of the meaning, experience and opinions of the selected participants and aims at understanding a phenomenon from the perspective of the participants.

Qualitative study is known for the natural nature of its setting (Patton, 2002: 39). Participants are approached in their familiar environment and open ended questioning allows the participant to express their views freely, thus ensuring the phenomenon unfolds naturally without any manipulation. In this study, the participants were interviewed in their familiar environment, their nursing education institution. The interview environment, together with the use of open ended questions, allowed them to freely express their views.

A qualitative study design is also known for being welcoming to any emerging information as the discussion deepens, it is therefore non-limiting and facilitates a view of the phenomenon in its entirety, as the participants expand and deepen the descriptions of their perceptions of the phenomenon under study (Patton, 2002: 40-41). This allows for dense descriptions of the findings. Qualitative research is effective for studying human perceptions, as it allows the researcher to gather the data in the form of words instead of numbers; its focus is on the qualities and meanings of the phenomenon as expressed by the participants (Jolley, 2013:90). It allows a discussion between the researcher and participants and as a result, the researcher can investigate deeper meanings as experienced by the participants.

In this study the phenomenon being investigated was the perceptions of undergraduate nurses on best practice in clinical facilitation. The qualitative research allowed the researcher to

investigate this phenomenon from the views of the nursing students and the data were expressed in words.

3.1.2 **Exploratory Research**

The exploratory design is undertaken when little is known about the phenomenon under study and can act as a foundational study (Botma, Greef, Mulaudzi and Wright, 2010:185; Polit, Beck and Hungler, 2001:19). Jolley (2013:81) states that explorative research aims at bringing understanding into the area being studied and which may lead to future studies. The explorative study aims at exploring the full nature of the phenomenon, its manifestation and the factors which relate to it (Polit, Beck and Hungler, 2001:19).

The literature reviewed for this study did not reveal any studies exploring nursing student's perceptions of best practice regarding the clinical facilitation of their learning, relating to the South African context. In this study, the researcher explored and hoped to gain deeper understanding, and generate new ideas and new knowledge on perceptions of undergraduate nursing student's regarding best practice in clinical facilitation of their learning.

3.1.3 **Descriptive research**

Descriptive studies aim to describe characteristics of the phenomenon and provide the reader with a picture of the situation as it naturally happens (Burns and Grove, 2001:248; Polit, Beck and Hungler, 2001:460). For this study the descriptive research approach was used to accurately describe the perceptions of undergraduate nursing students with regard to best practice in clinical facilitation of their learning.

3.2. SELECTION OF THE SITE

In qualitative research, selection of the site refers to the identification of the relevant area where the topic being studied can be researched; this site should have the potential participants who have knowledge on the topic being studied (Polit, Beck and Hungler, 2001:44). The site chosen for this study was the nursing education institution in association with an academic hospital in Johannesburg which is an accredited clinical placement facility for clinical education, where the undergraduate nursing students of a selected nursing education institution are placed for their clinical learning. The academic hospital has clinical instructors, employed by the hospital to facilitate learning to the nursing personnel. The clinical instructors (also called preceptors) employed by the nursing education institutions who place their undergraduate nursing students accompany their students to this clinical placement facility. The registered nurses in this academic hospital are also expected to assume a preceptorship role to the students.

3.3 THE CONTEXT OF THE STUDY

The context of the study is a setting, or the physical environment, where the action under investigation takes place. This is significant in qualitative research because it frames the research in its uniqueness of its natural setting (Patton, 2002:63).

The study was conducted in a nursing education institution which is associated with an academic hospital in Johannesburg, in Gauteng Province of South Africa. Undergraduate nursing students from the university are placed in this academic hospital, for their clinical practicum. In addition, clinical skills are taught in the university's Nursing Skills Laboratory and competency is assessed throughout the academic year by the university lecturers.

3.4 RESEARCH METHODS

Research methods refer to how the data was gathered and analysed and how the researcher ensured trustworthiness of the study and ethical considerations (Botma, Greef, Mulaudzi and Wright, 2010:199).

3.4.1 Population

Population is all the individuals who have some common characteristics defined by the sampling criteria which is established by the researcher (Botma, Greef, Mulaudzi and Wright. 2010:200).

In this study, the population was defined as all the undergraduate nursing students studying for the degree of Bachelor of Nursing, at the preselected university leading to registration as a Nurse (General, Community, and Psychiatry) and Midwife, who were placed in the preselected academic hospital for their clinical practicum. One hundred and eight undergraduate nursing students, from the university were placed in this preselected academic hospital: 48 first year students, 29 second years, 14 third years and 17 fourth years enrolled for the Undergraduate Nursing Degree in 2014.

3.4.2 **Sampling**

Purposive sampling was used in this study. Purposive sampling is a non-probability sampling method, whereby participants are selected because they are likely to generate useful data for the study (Burns and Grove, 2001:376). The advantage of purposive sampling is that it focuses on designing criteria which will allow participants having in-depth and rich information to contribute to the study; however its disadvantage is that it does not permit generalisation

(Patton, 2002:46). Purposive sampling was chosen for this study to allow participation of the participants who were identified as having experience of the topic under study.

A purposive sampling method was undertaken with second, third and fourth year undergraduate nursing students. These students were presumed to have adjusted to the clinical learning environment, as they would have completed first year and therefore would be able to give insight into their perceptions of best practice.

3.4.2.1 **Inclusion and exclusion criteria.**

- Nursing students who participated in the study had at least one year exposure to clinical teaching in an academic hospital in Gauteng; first year undergraduate nursing students were therefore excluded.
- Participants had to be willing to sign consent for participation and digital recording.

3.4.2.2 **Sample size**

The sample size of qualitative study is determined by data saturation, whereby no new relevant information is obtained (Polit and Beck, 2004:308). Saturation is reached when the researcher feels he/she has exhausted all avenues and no new findings are emerging, only repetition of the same findings (Botma, Greef, Mulaudzi and Wright, 2010:201). In this study the sample settled at 24 participants (N=24). Eight second year students, seven third years and nine fourth years participated in the three focus groups. As the researcher was conducting the last interview there was repetition of existing findings, with very little new emerging data, indicating data saturation.

3.5 DATA COLLECTION

3.5.1 Data collection Method

Semi-structured focus group interviews were the data collection method.

A focus group is a carefully planned group discussion on a topic organised for research purpose, it is a guided discussion monitored and recorded by the researcher. Focus groups are useful when the researcher is exploring perceptions and looking for a range of ideas (Greeff, 2005:287; Krueger & Casey, 2000:5).

In this study focus groups were used in order explore different views from a number of participants, with the aim of emerging ideas from the group; it was also useful for allowing students to share their ideas and most interestingly to view their similarities and differences in perceptions.

3.5.2 Data collection tool

The main data collection tool in qualitative study is the **researcher**, as she formulates meanings through her engagement in the study ((Botma, Greef, Mulaudzi and Wright, 2010:182). The researcher prepared herself for the interviews by planning them beforehand. The researcher designed the interview guide and presented it to her supervisor and co-supervisor for confirmation of the questions. The researcher revised the interview guide and became familiar with it; this was to ensure that during the interview she was focused on the facilitation of the focus group and on listening to the inputs from the participants, rather than on understanding the interview guide. The researcher entered the data collection site with enthusiasm and curiosity, showing interest to the participants.

An interview guide is a set of pre-planned open ended questions which guides the interview, (Botma, Greef, Mulaudzi and Wright, 2010:209). The importance of having an interview guide is to keep the focus of the discussion within the objectives of the interview, while creating flexibility to explore and probe the input of the participants (Patton, 2002:343). An interview guide also ensures that different focus groups are conducted in a similar manner.

The interview guide was designed and used to direct the interview (Appendix: 1); two central questions were asked during the interview, with unstructured open ended questions to probe and get more clarity during discussion. The researcher defined these concepts (Best practice, Clinical facilitators, and Clinical practicum), to make sure everyone was clear on the phenomenon being studied.

The opening interview question was:

As student nurses, what do you think constitutes best practice in your clinical practicum experience with regard to clinical facilitation?

- Students were asked to think back to the first year until their current year of study and identify anything done by clinical instructors which they considered best practice regarding their clinical learning.

A second probing question was developed during the first focus group interview to allow students to clarify and specify their perceptions of best practice clinical facilitation.

If you were sure all you ask will be granted, what would you ask clinical facilitators to do to ensure best practice clinical facilitation?

- This question was aimed at achieving the research objective which asks what type of clinical facilitation undergraduate students believe should be offered by clinical facilitators in the clinical area in order to best facilitate their learning.

3.5.3 Data collection process

Preparing for data collection:

The following procedures were done to prepare for data collection prior to conducting the focus groups.

- Verbal permission was sought from the class teachers of the undergraduate nursing students in a selected nursing education institution, to invite the nursing students to partake in the study.
- All the second, third and fourth year undergraduate nursing students were approached in their class during the time arranged with the class teacher and students were invited for voluntary participation in this study.
- An information letter (Appendix: 2) was given to the participants explaining the study, with the researcher reading through the letter in the participants presence and clarifying any ethical issues relating to this study, the purpose and data collection method were explained and any questions from the participants answered.
- The process of participating in a focus group was explained in detail by the researcher.
- The researcher and the possible participants agreed on a data collection date, time and venue.
- A reminder message was sent to each class representative to further confirm the date, time and venue to all the possible participants.

- All interviews were conducted at a time convenient to the students and as a result interviews were done on different days and at different times, depending on the availability of the group to be interviewed.
- The venue was the boardroom of Nursing Department at the University of the Witwatersrand.

During the interview sessions:

- All participants signed consent forms (Appendix 3) to participate and for the digital recording of the focus groups, prior to the focus groups commencing.
- A circle seating arrangement was used to encourage a sense of equality and encouraged participation, as well as to ensure clarity of recorded voices.
- Refreshments were available to the participants.
- The researcher introduced herself and the co-facilitator and explained their roles.
- The researcher welcomed everyone to the session, thanked them for attending and explained the purpose of the interview.
- The researcher explained some basic ground rules e.g., all contributions were valuable, there is no wrong answer, everyone would have an opportunity to talk, no one would be pressured to talk and participants were urged not to discuss information shared in the focus group outside of the group.
- The concepts such as clinical facilitation and best practice and clinical practicum were explained and defined for the participants.
- The researcher conducted the focus groups, using an interview guide in the presence of her supervisor or co–facilitator.

The researcher interviewed second year undergraduate nursing students first, followed by third year students and as the researcher was interviewing the fourth years there was already evidence of data saturation as there was repetition of ideas from the previously conducted focus groups.

The co-facilitator of the focus group wrote field notes, operated the digital recording apparatus and acted as a time keeper. There were no distractions to be managed.

- The first focus group was held on the 8th of May 2014, with eight participants and lasted one hour. The second focus group interview was conducted on the 9th May 2014, had seven participants and lasted 55 minutes. The final focus group interview, on the 23 June 2014, had nine participants and lasted one hour.
- The recorders were placed in a good position to capture the voices clearly.

3.6 DATA ANALYSIS

Data analysis in qualitative studies is a process of preparing and organising and interpreting of non-numerical data, for the purpose of drawing meaningful conclusions (Polit, Beck and Hungler, 2001:469). In qualitative study, there are overlapping periods of data collection and data analysis and as the researcher is the tool for data collection and analysis, data is analysed as it is received (Botma, Greeff, Mulaudzi and Wright, 2010:221).

The method of data analysis for this study is discussed and the findings presented in detail in Chapter Three. Cresswell's method of data analysis (Cresswell, 2009:184) was implemented.

3.6.1 Organising and preparation of data

All interviews were transcribed word for word by the researcher, (Appendix: 4); two recorders were used to ensure audibility for the transcription. Participants were allocated numbers to identify them and protect their identity and for direct quoting to enhance the credibility of the discussion and findings. Field notes were read while listening to the recorder to ensure consistency of the data. The researcher made additional summaries of ideas which arose during the interview, immediately after each focus group interview.

3.6.2 Developing a general sense

As the researcher was transcribing the data, the researcher listened repeatedly to the recorded data. Re-reading of data was done across all interviews, developing a general sense of whole and the researcher was able to reflect on its meaning; any underlying meanings were written on the side of the margin. When transcribing was completed, hard copies of data were printed.

3.6.3 Coding of the data

The research question was reviewed. The participant's perceptions which described best practice in clinical facilitation were noted and highlighted across all interviews. Perceptions that occurred frequently in each focus group were noted and underlined, forming text segments. A phrase was assigned that best described the text segment, forming codes. The researcher used the most descriptive wording to give a topic for all similar codes to form themes. The related codes were grouped together and subthemes were identified in each theme where appropriate. These themes were then analysed for each focus group and across the other focus groups. Multiple perceptions from different respondents and from each focus group were identified and

described using participants' quotations to describe and explain the phenomenon in more detail, as well as to increase the trustworthiness of the data. .

3.6.4 Representing the findings

Summary of findings, themes and subthemes were represented in a table form. Findings were further represented in the form of an in-depth description, with direct quotation from the participants. An integration of the literature review and findings was then done to extend and explain the themes and add to the richness of the findings. This section is described in depth in Chapter Four.

3.6.5 Interpretation of the data

According to Cresswell (2009:186), the interpretation stage involves making sense of the data through reflection, including the researcher's personal views and comparing new findings with past studies. The overall meanings of the findings are discussed in detail in Chapter Five.

3.7 TRUSTWORTHINESS

Trustworthiness is a way of evaluating the quality, validity and rigour in qualitative research. Polit and Beck describes trustworthiness as the extent of confidence the researcher has in the data (Polit & Beck, 2004:735). According to Lincoln and Guba (1985) as cited in Polit and Beck (2004:430), trustworthiness is a method of evaluating the findings and research process using the following four criteria: Credibility, Transferability, Dependability and Confirmability.

3.7.1 Credibility

Credibility refers to the honesty in the truth of the data and its interpretation (Polit and Beck, 2004:430). It is the plausibility of the study's findings, measuring how congruent the findings are with the reality. It addresses congruency between the participant's views and the researcher's presentation of findings. Jolley (2013:251) describes credibility as the "degree to which the researcher's interpretation of the data can be justified in data itself."

Credibility was ensured by taking the below mentioned measures into consideration.

3.7.1.1 Member Checking

Member checking refers to sharing of findings with the participants to verify accuracy (Creswell, 2009:191-192). Member checking can be done informally during the interview process and may be arranged formally after data analysis (Polit and Beck, 2004:433).

- Informal member checking was done during the interviews through clarification with the participants. This was achieved through the researcher summarizing and re-stating the group's findings during the interview.
- Findings were confirmed with a group of participants after the final coding of themes to verify the truth of findings.

3.7.1.2 Authority of the researcher

The researcher is a major instrument in the data collection and analysis process. The experiences, qualifications and prior knowledge the researcher brings to the research field is an important indicator of the credibility of the researcher (Patton, 2002:566).

- The researcher has over five years of experience in nursing practice, during this time she has been assuming the role of a Nurse Preceptor to novice nurses and nursing students (post-basic students) who are placed in her unit, in conjunction with her other nursing duties. This has enhanced the researchers experience in clinical facilitation.
- The researcher has completed a research methodology programme and has a full understanding of the research process and procedures.
- The researcher's supervisor and co-supervisor are highly experienced in supervision of post-graduate degrees and were actively involved in the data collection and analysis phase of the study.

3.7.1.3 Frequent debriefing sessions between a researcher and supervisor

Shenton (2004:67) acknowledges the frequent discussion between the researcher and her supervisors as an important tool to ensure credibility, as it widens the view of the researcher to the study, opens opportunity for alternative approaches and assists the researcher to recognise her own bias.

- The researcher maintained continuous communication, through meetings and discussions, with her experienced research supervisors, who verified all the stages of this study.

3.7.1.4 Ensuring honesty in informants

Shenton (2004:67) recommends strategies to ensure honesty from the participants; these are factors which could influence the truth of the data due to manipulation of the participants by the researcher, or being coerced into participating.

- In this study participants were invited to voluntarily participate in the study.
- The right to withdraw at any stage with no resulting adverse consequences was explained.
- Participants were ensured that participating or not will not affect their academic findings.
- The researcher and the supervisor, who was also the co-facilitator for focus group interviews, were not directly involved with the participants in their clinical education, therefore the participants were free to share their perceptions without being concerned about any adverse cause or effect.

3.7.2 Transferability

Transferability is the measure of the extent in which the study can be transferred to other settings or groups (Polit and Beck, 2004:435). It evaluates if the conclusions of the study can be generalised to other settings (Brink, 2008:119; Jolley, 2013:210). In a qualitative study every study is unique to its context, as it is made up of a particular researcher phenomenon, in a particular interaction with a particular participant, transferability is possibly a weakness of any qualitative research approach (De Vos, 2005:346).

In this study it might be difficult to generalise the findings, as different students may have different perceptions regarding best practice in clinical facilitation of their learning due to different circumstances influencing each clinical learning environment. However, the thick dense detailed description of the context of the study, sampling methods, data collection methods and data analysis makes it possible for a researcher, who wishes to transfer findings to different or similar context, to be able to make judgment of how appropriate the transfer would be.

3.7.3 Dependability

Dependability means consistency of data over time and conditions (Polit and Beck, 2004:430). It evaluates if similar findings could be obtained should the study be repeated with the same participants in a similar context (Botma, Greef, Mulaudzi and Wright. 2010:233 and Jolley, 2013:210).

- Thick and dense description of the research methodology used to conduct the study and dense description of sample characteristics, context of the study, data collection methods and data analysis processes were detailed, with literature support included.

3.7.4 Confirmability

Confirmability refers to the objectivity of the data collected, data analysis and description of findings (Polit and Beck, 2004:430). It is the measure of how the research findings truly reflect the collected data with no bias. Botma, Greef, Mulaudzi and Wright (2010:292) state that "there should be congruency between two or more people about the accuracy, relevance and meaning of data." An audit trail was created which included the following measures:

- Focus groups were audio-recorded and transcribed verbatim; field notes were written.
- All raw data, analysed data, products of reconstructed data, draft of final report were kept, and is to be kept in safe for five years .
- The researcher collected data until data saturation was reached.

Independent data coding was done by a researcher and the research supervisor; consensus was reached after discussion about the emerging themes.

3.8 ETHICAL CONSIDERATIONS

It is the responsibility of the researcher to ensure the research is conducted in an ethical manner (Brink, 2008:30). Protection of the rights of human subjects when using human participants is a significant factor to consider when planning the research and in South Africa ethical issues relating to a proposed research are evaluated by an accredited research ethics committee, who are also responsible for granting permission to proceed with the study (Brink, 2008:12).

3.8.1 Permission to conduct the study

Permission to conduct this study was sought and granted from the following:

- The Postgraduate Research Committee, on the 5th March 2014.
- The University of the Witwatersrand Human Research Ethics Committee (Medical), on the 28 March 2014, Protocol Number: M140382 (Appendix 5).
- Permission to invite nursing students to participate in the research study was sought and granted on the 16 April 2014, from the Head of Department at the selected Nursing Education Institution from which participants were registered as undergraduate student nurses (Appendix 6).

3.8.1.1 Informed consent

With regard to informed consent, Burns and Grove, (2001), describes informing as referring to the transformation of the information from the researcher to the possible participant and consent as referring to the participant's agreement to participate in the study. Brink (2008:34) and Burns and Grove (2001:206) agree that the prospective participant should have sufficient understanding of the information given to him by the researcher and must also understand the type of information needed from him, as well as the fact that he has a right to refuse

participation. This information empowers the prospective participant to make informed voluntary consent.

- In this study the prospective participants were undergraduate nursing students in a selected nursing education institution. They had good understanding of the information given by the researcher as it was related to them in English, which is the language of tuition in the selected university.
- It was conveyed verbally by the researcher and hard copies of the letter of introduction and invitation to participate were given to all prospective participants.
- A clear detailed description (Appendix:2) of the purpose of the study, the proposed plan of conducting focus group interviews and the use of a digital recorder were explained to all participants prior to them signing consent for participation.
- The potential participants were given an opportunity to ask any questions about the study to the researcher.
- The right to withdraw at any stage was explained to the potential participants to ensure they did not feel coerced into participating.

3.8.2 Confidentiality and Anonymity

Confidentiality refers to the researcher's responsibility to protect the gathered information from being disclosed to any other person and anonymity refers to the protection of the identity of the contributors of this information (Brink, 2008:34-35). Participants were urged not to relate the information that was discussed during focus group interviews, outside of the interviews.

- No identification of names was used on this research report; participants were allocated numbers during the focus groups and these appear in the report.
- Data gathered from participants was kept safe in a locked cabinet. Only the researcher and her supervisors could access the data. The researcher transcribed the data so as to prevent violation of confidentiality.

3.8.3 Non-maleficence

Non-maleficence refers to the participant's right to protection from any discomfort and harm (Burns and Grove, 2001:203).

- Participants were informed that the decision to either participate or not in this study would not affect their performance findings.

Participants were assured there was no harm in participating in this study and were allowed to withdraw at any time of the data collection period, with no penalty to themselves.

3.8.4 Justice

Justice in research refers to the right to fair selection and treatment of participants. Participants ought to be selected based on the criteria enhancing the achievement of the research objectives, not as per researcher's personal preferences and all participants must have similar treatment (Burns and Grove, 2001:202-203).

- Selection criteria for prospective participants was based on formal inclusion and exclusion criteria.
- Participation was voluntary.
- All participants were treated the same, were asked the same questions and every participant's opinion was regarded as of equal importance.

3.8.5 Respect

Respect refers to the participant's right to self-determination, which may be violated by deceiving participants, threatening them or giving them excessive reward to obtain compliance (Burns and Grove, 2001:196).

- Participants were informed of their right to choose to voluntarily participate in the study.
- Participants were treated with respect, during all the interaction of data collection.
- Participants were urged to respect one another's opinion during focus group discussions.
- There were no benefits promised to participants as a result of participation in the study.

The researcher returned to the participants with the final findings, to ensure the resultant report was an accurate reflection of their perceptions (Member checking).

3.9 CONCLUSION

In this chapter, research design and methods were discussed. In the next chapter the findings of this study will be presented.

CHAPTER FOUR

FINDINGS AND COMPARISON WITH LITERATURE

4.0 INTRODUCTION

This chapter will describe the findings of the focus group interviews which were done to determine the perceptions of undergraduate nurses with regard to best practice clinical facilitation of their learning in an academic hospital. Literature which supports or refutes the findings has been discussed for each of the findings. The research question asked was: What do undergraduate nurses believe is best practice with regard to clinical facilitation? The research objective was to determine what type of clinical facilitation undergraduate students believe should be offered by clinical facilitators in the clinical area in order to best facilitate their learning.

Two open ended questions were asked during focus group.

- Question1: As student nurses what do you think constitutes best practice in your clinical practicum experience with regard to clinical facilitation?
- Question 2: If you were sure that all you ask for would be granted, what would you ask clinical facilitators to do to ensure best practice clinical facilitation?

4.1 FINDINGS

Data analysis led to the identification of three main themes with subthemes:

Table 4.1: Themes and Subthemes

Themes	Subthemes
4.1.1 Facilitation of clinical learning in the simulation area.	4.1.1.1 Pre-contact preparation 4.1.1.2 Technique of demonstration 4.1.1.3 Use of teaching aids 4.1.1.4 Optimising group learning
4.1.2 Facilitation of clinical learning in the patient care areas	4.1.2.1 Standardisation of procedures 4.1.2.2 Allocation to clinical areas 4.1.2.3 Support from University staff 4.1.2.4 Communication between university and ward staff 4.1.2.5 Support for students
4.1.3 Methods/types of learning	4.1.3.1 Preceptorship 4.1.3.2 Questioning 4.1.3.3 Nurse's round 4.1.3.4 Inter-Professional discussion

4.1.1 Theme 1: Facilitation of clinical learning in the simulation area

4.1.1.1 Pre-contact preparation

The participants of this study highlighted the importance of being informed about what to expect in their clinical teaching sessions in the clinical laboratory. The participants wanted to be

able to plan and prepare themselves prior to these sessions as this would allow them to develop interest in the scenario and help them interact with the learning experience and as well as having reflective discussions on the subject.

Quotes by some participants relating to the planning of teaching clinical skills are as follows:

"Ok, before you get to the Dem room, it's good that we have paper telling you which skills that you gonna do before we get to the class, that's good." (Participant 1, 2nd year)

Price (2005:8) describes features of a successful demonstration of clinical skills as having a logical structure to enhance learning. Price further asserts that when preparing for a demonstration, students must be informed of what the clinical instructor is intending to demonstrate. Bruce, Klopper and Mellish (2011:268) believe students must have information about the procedure to be demonstrated, specifically they must be aware of the crucial points to note during demonstration. With this in mind, having student's preparing themselves for demonstration will ensure their interest blends with what they read in literature and what they see during demonstration.

4.1.1.2 Technique of demonstration

There were two points of view, mentioned in the focus groups, about how to format the clinical teaching of a skill. To some students best practice was to see the whole procedure demonstrated without any discussion, but to discuss it later.

> *"It's better you do the skill (procedure), do the whole skill (procedure) with no one distracting or asking questions, or comments, do the skill completely and talk later about the skill." (Participant 1,2nd year)*

Other students believed the most prudent action was for the clinical instructor to break down the complex procedure into small manageable portions. Student's perceptions of a well demonstrated skill is described in the following narrative:

> *"So they (Clinical Facilitators) will do one section, then I'll follow through that, then they will do the next session and I'll follow through that and the next session and then I'll follow through on that. Not all in one go and then expect me to do it. Rather do it in step by step." (Participant 1, 3rd year)*

There is evidence of disagreements on effectiveness of demonstrating the skill as a **whole** or breaking it to **small components** in the literature (Quinn and Hughes, 2007:370). Both methods are not without disadvantages. It may be challenging for some students to grasp the whole procedure when demonstrated entirely, whereas component learning is criticised for time wasting, as there is a need to re-learn the whole procedure after mastering its small components. Advantages of demonstrating a skill as a whole is that students perceive it as a whole from the beginning and are able to identify parts that are still challenging to learn. The advantage of learning the small component of a skill is that students are motivated with immediate grasp of each component (Quinn and Hughes, 2007:370). The complexity of the procedure and lack of background in the demonstrated skill can be used to determine the need to break it down to small components. Breaking down complex procedures into their small portions is considered an important tool for successful demonstrations (Price, 2005:8).

4.1.1.3 Use of teaching aids

Participants suggested the format of giving the theory related to a skill, followed by demonstration of the skill, re-enforced by watching a video, is very effective in their learning of clinical skills. This is how some participant's verbalised this:

"Give lecture first, demonstrate the skill and then video to re-enforce what we learnt."(Participant 2, 2nd year)

This finding is in keeping with that of McNett (2012: 328) in his study, which intended to identify the effective methods of teaching psychomotor skills, he found that a lecture combined with a demonstration plus computer use was more effective than each method used alone. Maginnis and Croxon (2010:3) also believe that educators should repeat theory when demonstrating clinical skills and support the use of different types of teaching aids such as using videos to blend theory into the demonstration of a procedure, thereby bridging the theory practice gap.

4.1.1.4 Optimising group learning

The participants in this study suggested that the best practice in demonstrating a skill is achieved when students are divided into small groups in order to increase their ability to observe the demonstration and to allow students a chance to practice the procedure and take part in the learning experience.

One participant stated:

"To have the facilitators either split us into smaller groups, or they come on- one- on- one with the students, this is how we will get to learn more in practical, because when we have twenty people all watching, some people can't see, some people get distracted so its smaller groups or one on one that helps because we are learning." (Participant 2, 2nd year)

Attaining motor skills requires practice and practice entails repetition of a procedure. Quinn and Hughes (2007:74) indicate that students' progress through three phases, namely:

- Understanding the skill and how to perform it accurately.
- Refining movements and becoming more consistent in performance.
- Practising until the skill is spontaneous to the level that a student may perform it without thinking about the steps.

Small groups will allow the students to do the procedure repeatedly until they achieve the above mentioned three phases.

There is mention in literature that, apart from the skill being well demonstrated, students need enough time to repeatedly practice the procedure. A study by Strand, Naden and Slettebo (2009:19) on students learning in the laboratory, found that students noted that a hands-on experience helped them to remember clinical skills, however students emphasised the fact that practical skills need practice and overcrowded skills laboratories combined with poor practice time was associated with poor learning experience. Ensuring that every student can see the demonstration is essential for an effective clinical demonstration (Bruce et al. 2011:266), but is difficult to achieve if the student numbers are too large to afford everyone a clear view.

4.1.2 Theme 2: Facilitation of clinical learning in the patient care area

4.1.2.1 Standardisation of procedures

Students verbalised that a best practice in clinical facilitation is the consistency in performing procedures in the Nursing Skills Laboratory and in the clinical area which helps them to transfer skills learned in the lab to real situation. Students stated they get confused when deciding which one is evidence based practice, when there is a discrepancy between what they learn in the Nursing Skills Laboratory and what they find practiced in the wards.

", ……, best practice facilitation will be, whatever skill we learn in the department we actually do the very same process in the wards, because sometimes there is a big discrepancy, we learn it this way in the skills lab, and when we get into the ward the sister's do it differently." (Participant1, 3rd year)

Houghton, Casey, Shaw and Murphy (2012:1966), in their study on student's experiences of implementing clinical skills in the real life situation, found that students experienced inconsistency between what is taught and what is practiced and they advocated a need for principle focused teaching, whereby differences in performing procedures may be allowed as long as certain principles are obeyed. These findings are parallel with those of Maginnis and Croxon (2010) in their study entitled "Transfer of learning to the nursing clinical practice setting," which revealed that even when students viewed themselves as sufficiently prepared in the clinical laboratory and well equipped for clinical practice, they still found some discrepancies in real practice which were due to the professional nurse's preferred ways of performing procedures (Maginnis and Croxon, 2010:4).

4.1.2.2 Allocation to clinical areas

Under this sub-theme there were two areas that the participants identified as best practice, namely:

(a) Longer placement period. (b) Alignment of their practical placement with theory.

(a) Longer placement period

Participants in this study perceived best practice in clinical facilitation as being placed in a clinical practicum for longer than six hours per week. The participants mentioned that in their second year, they are required to know their patients holistically, but when only allocated six hours a week they feel that this is not possible.

One participant who strongly believed in this practice stated:

"…..…You really cannot learn much from 7am to 1pm, ……you have 4 days in a month to go to that specific ward for six hours per day and you get there…, they expect us to know our patients……(if) we work seven to seven and we get enough exposure,…. I feel that for something to be regarded as achieved best practice it would be good if we had more exposure." (Participant 1, 2nd year)

Levett-Jones, Lathlean, Higgins and McMillan (2008:11-12) studied the relationship between duration of clinical placement and the student's feeling of belonging during their clinical placement. The findings of this study revealed that during the first two to four weeks of a placement, students undergo a phase of adjusting to the clinical placement area. During this phase the students focus less on achieving their learning objectives as they are mostly overwhelmed with doubt and nervousness. Levett-Jones et al. (2008:14) believe that allocating students for less than four weeks in one clinical area is not considered best practice, as extended placements promote belonging in the students, which then enables self-directed participation to their clinical learning. However, in this same study it was found that placing students in a negative practice environment for an extended period was not valuable to students learning (Levett-Jones et al. 2008:14-15). In contrast, Gilmour , McIntyre, McLell, Hall and Miles (2013:e21) found that the quality of student learning in the clinical environment depends on the effectiveness of the preceptor whom the student is paired with, rather than the length of exposure. The South African Nursing Stakeholders suggest that the student should not be placed for less than a month for role taking. Role taking is defined as "*being allocated a patient and being part of ward team"* (Nursing Education Stakeholders, 2012:4).

(b) Alignment of the clinical placement period with theory

Participants also believed that being allocated to the clinical areas soon after demonstration is best practice as it has a positive impact and reinforces skills learnt in the demonstration room and the transfer of skills to the real life situation.

"…..it would help if the demonstrations we've got in the dem room (Nursing skills Laboratory) and then the allocations that we have got in the clinical setting, like correlated with each other. Because it doesn't help you teach me something in Jan or you demonstrate something in January, but you are only going to allocate me to that particular ward let's say in May/June. Whatever I was taught then, it's still there but it's not as fresh." (Participant 4, 4th year)

When planning student's allocation to clinical practice it is important that the continuity of learning is ensured through aligning practical placement in the same time with its related theory (Nursing Education Stakeholders, 2012:5)

4.1.2.3 Support from university staff

Participants in this study believed that clinical facilitators (nurse educators) from the university should be visible and available to them in the clinical placement area. During these visits they mentioned that they expect the educators to check if they are doing skills correctly, assist them in implementing theory to practice and give tutorials which can integrate what they learned in class with what they are expected to do in the practice area.

One participant described this best practice in the following narrative: *"Have one on-one with the Facilitators, and I like them to come from university to check on us more often, to check that we are ok, and see if we are doing things properly." (Participant 2, 2nd year)*

Another participant voiced this as: *"For the facilitator to teach the skill in the ward on alive human being. I would like to see the clinical facilitators improvise. Sitting in class and doing nursing care plans, you forget because you don't apply. I would like the person who lectures in PBL to do the nursing care plan and go to the ward and apply this that is discussed in PBL." (Participant 7, 2nd year)*

One participant further elaborated: *"I think another thing with regards to visibility is not just coming to the ward and asking the students who is in the ward, how is the ward, how you finding it, are you comfortable, but maybe the clinical facilitator would take the initiative of saying, ok I will come to the ward, yes I'm checking up on you. This is what we've done in class, let's practice one of these tasks together. Let's see where you are lacking, whether it's an admission of a patient - let's do an admission of a patient, let's quickly find a patient, let's do one admission together, then have a small discussion. So it's more like having like mini tutorials in the ward so to speak but to try incorporate both theory that we've learnt in class but also putting that into practice." (Participant 4, 4th year).*

Brown, Herd, Humphries and Paton (2005:89) studied experiences of a group of senior student nurses who were involved in a formal continuous teaching-learning relationship with nurse educators during the first two years of their course in a university in Scotland. Findings of this study revealed the pivotal role of a nurse educator in supporting students in the clinical area, was seen as guiding and describing learning needs of the students to the students and to the staff. In another study conducted in Ireland by McSharry, McGloin, Frizzell and Winters-O'Donnell (2010:194), the role of the nurse educator as a mediator between academic and clinical was highlighted as supporting student's clinical practice. Visibility of the nurse educator in clinical practice was found to be of major importance in a study, also conducted in

Ireland, by Meskell, Murphy and Shaw (2009:789) who explored the clinical role of Nurse Lecturers from the perspectives of educationalists, clinicians, policy formulators and students involved in nursing education. The South African Nursing Education Stakeholders (2012) affirm these expectations in the current proposed model of education and training, by saying that nurse educators take responsibility for the overall quality of the nursing student's clinical learning and therefore nurse educators should take an active clinical preceptor role (Nursing Education Stakeholders Group:2012:4).

4.1.2.4 Communication between university and ward staff

Participants expressed an appreciation of communication between the university nursing department and the person in charge of the area of placement. They considered well-managed open communication as best practice, as it ensures they are expected in the placement area making the students feel welcome on their arrival. Open communication would also assist the hospital staff members to structure clinical learning to suit the student's needs.

One of the participants articulated his perceptions*: "I've seen the best facilitation … when there was communication with the clinical facilitators in our department and clinical facilitators in the hospital that we are working in, so that there is ….co-ordination." (Participant 3, 4th year)*

Another participant related: "*It would be better if the Facilitators from the University could talk to the Sister in charge and tells them about our learning objectives relatively to being placed there."* (Participant 5, 3rd year)

The link between the Nursing Education Institutions and clinical placement area has an influence upon the quality of clinical placements, thus it is important that these two organisations keep good communication channels open with regard to student placements and

the students' learning objectives (Peters, Halcomb, and McInnes, 2013:186). In agreement with these findings are Dale, Leland and Dale (2013:1-2) who, in their study on factors that facilitate good clinical learning experience, found that being expected in a clinical area, was associated with clinical supervisor's preparedness to teach and student's feeling of being welcomed. Students noted these as important factors which had a positive influence on their learning in the clinical placement areas. Moreover, Elcigil and Sari (2011:70) did a study determining facilitating factors in clinical education for nursing students and the findings showed that nursing student's clinical education was facilitated better when the nursing staff were informed of student's learning objectives.

4.1.2.5 Support for students

Participants verbalised challenges in transferring skills to real life situation. They believe the person who teaches in the nursing skills laboratory should be the same person who assists them to adapt the learned skill in the clinical practice in order to achieve best practice. They presume this would ensure reinforcement of undoubted knowledge, as they mostly face challenges of inconsistency due to lack of resources in real practice which lead to individual practitioners performing skills differently, as per requirement to improvise. As a result the students remain unsure of the correctness of the practice they have adapted to.

> One participant voiced this as: *"For the facilitator to teach the skill in the ward on an alive human being." (Participant 7, 2nd year)*
>
> Another participant had this to say*: "…. if you have a clinical facilitator that taught you theoretically and in the Sim Lab (Nursing skills Laboratory) and go with you in the hospital, ….. You enforce principles there once you've worked with him in the Hospital*

then should someone else comes and work with you, you know you can show them the right way."(Participant 1,3rd year)

The proposed model of clinical education and training in South Africa recommends that the Nurse educators should do group supervision for their nursing student's clinical preceptors to ensure the continuity and standardisation of skills training between the lecturers and the clinical preceptors (Nursing Education Stakeholders, 2012:4). Clinical preceptors according to this model are employed by nursing education institutions and therefore may be able to teach skills both in the Nursing Skills Laboratory and repeat it in the clinical practice.

4.1.3 Theme 3: Methods/types of learning

The participants of this study pointed out teaching strategies that they perceived as best practice in clinical facilitation of their clinical learning, namely: **preceptorship, questioning, nurse's grand round and attending inter-professional discussions.**

4.1.3.1 Preceptorship

Participants believed that having someone available as a resource for learning and for supervision and guidance in their clinical practice ensured effective learning, as they could feedback of their performance, troubleshoot and seek confirmation during their practice of nursing skills in the practical area. They mentioned that meaningful supervision is well attained if they are paired with a registered nurse who has interest in teaching.

The following participants' quotes depict these findings:

"I would say that it makes a difference when you get a registered nurse and you paired with her……., (and) she involves you … asks you questions, and if you do not know she will explain to you and she brings theory , it helps if they teach you," (Participant 3, 2nd year)

Another participant added: *"For example, maternity, I'd be put with a sister, I'm going to be working with her like one- on- one or, I'm working with her, she would be like ok, guys we are going to do abdominal examination. What do you see, how do you do it, so you find good instances like that.' (Participant 3, 4th year)*

Another participant affirmed: *"……..because if you are there alone, for example palpation, I'll be like, I'm feeling something and then I would interpret according to what I think it is, whereas if someone superior is there, they can let me know if what I think I am feeling is the right thing to feel… so overall supervision is beneficial." (Participant 4, 4th year)*

According to Bruce et al. (2011:255), preceptorship is a teaching strategy whereby an experienced nurse is paired with an undergraduate student for a set period of time. During this time the nurse (preceptor) assumes the role of modelling how things are correctly done in the nursing practice and becomes a resource for student's learning; the students observe and ask questions where necessary. The preceptor teaches and assists the student to achieve integration of theory and practice based on the learning objectives of the clinical placement and the preceptor supervises the student's practice. Mills, Francis and Bonner (2005:5) describe preceptorship as a method of using an experienced clinical staff member to provide supervision to undergraduate nursing students to prepare them for practice. Esmaeili, Cheraghi,Salsali &Ghiyasvandian (2014:465) also discovered that the presence of an instructor beside the student increases student's confidence.

In South Africa, the role of a preceptor is assumed by the registered nurse in addition to her clinical nursing responsibilities, however according to the proposed model of clinical nursing education and training, the clinical preceptors are specifically employed by the Nursing Education Institution for this task (Nursing Education Stakeholders Group, 2012:2).

4.1.3.2 Questioning

Participants from all the focus groups verbalised the benefits of question and answer sessions with their lecturer when on the wards. They expressed this as being challenged to reason and support indications for your action.

"…..I think it really helps that when they (lecturers) come from (the nursing education) institutions and they start asking you, asking questions challenging you, why you doing what you doing….. So challenging us helps, as we become more involved in our practical." (Participant 1, 3rd year)

Use of questioning as a teaching method is a recognised way of assisting students to reflect on their experiences, or to guide them to deeper meanings thereby facilitating critical thinking and encouraging active participation (Russell, Comello and Wright, 2007:1). Russell, Comello and Wright (2007:1) state that educators should relate their questions to the students desired learning objectives and should use Bloom's taxonomy of cognitive learning as a framework for structuring questions. Botma, Jeggels and Uys (2012:4) support the use of questioning for clinical teaching, saying that it ensures the clinical instructor assesses the student's level of prior knowledge and builds on it, thus challenging the student's thinking to enhance deeper learning.

4.1.3.3 Nurse's Grand Round

Students verbalised that they don't learn much on the routine nursing handover, as it is a summary for continuity of patient care and mostly its educational purpose is not emphasised. Students felt it would be beneficial to have a Nurse's Grand Round that is education specific through discussion of patient diagnoses and their plan of nursing care and management.

This is how some participants expressed their wish for this initiative:

"..like what the doctors do, they come to the ward with the whole team of doctors, and the one who teach them, they go from one bed to the other, discussing the patient problems and their plan of care and management. If we could have that from the nurse's point of view, we go bed to bed, discussing the patient management and how it could be done better." (Participant 4, 2nd year)

Another participant supported this: *"That we have nurses round where we actually have chances to share and hear other people's views and ideas and gain knowledge on patient care." (Participant 5, 2nd year)*

Nursing Grand Rounds are a nurse led analysis, review and discussion of patient care, with the outcome being to focus on the role of a nurse and not the medical interventions. This teaching strategy improves learner's knowledge, patient care and nursing practices through comparing current practices to evidence based practice and nursing standards (Close and Castledine, 2005:982). Laibhen-Parkes, Brasch and Gioncardi (2014:1) believe that Nursing Grand Rounds are an innovative method for nurses to be kept up to date about evidence based care and knowledge, exclusive to their patient population. Odedra and Hitchcock (2012:185) commend

Nursing Grand Rounds as an effective teaching method as it ensures that the nurse's role is promoted due to its nature of focusing on nurse's actions and reflections on patient outcomes.

4.1.3.4 Attending inter-professional discussion

Participants believed that being part of multidisciplinary team, such as the Mortality and Morbidity (M & M) meetings, made them feel part of the team, realise and strengthen the value of their role in the team.

"I like it when we attend M&M meetings in the hospital on Wednesday morning, the whole team discuss on what should have been done, why was is not done. It makes a difference because it makes you realize that doing or not doing of something could make a life or death kind of a difference. You also see and feel part of the multi-disciplinary team."(Participant5, 3rd year)

Mortality and Morbidity meetings set a platform for learning from medical errors, patient complications and system failures, with the intention to positively influence quality improvement. Illingworth and Chelvanayagam, (2007:123) support this notion that inter-professional education assists the students to identify their role in the multidisciplinary team and thus learn to appreciate and value the role of other professional categories.

4. 2 CONCLUSION

This chapter presented the research findings according to the themes and subthemes which emerged from the data analysis of the focus group interviews with the participants. Findings were supported with literature. Chapter Five will conclude the research report with the discussion of the findings, recommendations and limitations of the study.

CHAPTER FIVE

DISCUSSION

5.0 INTRODUCTION

In the previous chapter the findings of the study were stated and compared to the existing literature. In this chapter the researcher will discuss the findings and the conclusions drawn from the findings of the three focus groups conducted. The recommendations and limitations of the study are also discussed in this chapter.

5.1 DISCUSSION OF FINDINGS

The research question that was asked was: **What do undergraduate nurses believe is best practice with regard to clinical facilitation?** The objective of this study was to determine **what type of clinical facilitation undergraduate students believe should be offered by clinical facilitators in order to best facilitate their learning.**

Findings of this study revealed the perceptions of undergraduate nurses regarding what they considered to be best practice clinical facilitation of their learning in the simulation area and in the patient care areas. Some teaching methods were also suggested as effective in their clinical learning.

5.1.1 Facilitation of clinical learning in the simulation area

The findings of this study promote the need for effective pre-contact preparation of the clinical learning session, including deciding on which method will be used to demonstrate the procedure and optimise group learning.

Participants in this study believed that in order to achieve best practice clinical facilitation of their learning in a simulation area, clinical facilitators should inform them of the procedure to be demonstrated prior to the clinical teaching session. It is the researcher's opinion that informing students about which procedure will be demonstrated in the next session may not guarantee that they will plan and prepare towards the session. However if they do prepare, through reading about the topic, it can facilitate their clinical learning as they will be more familiar with the theory relating to the procedure and would then concentrate on application of that theory. Discussion of theory before demonstration becomes a revision and takes a shorter period of time if students have read before the session. Informing students about the procedures to be demonstrated in the Nursing Skills Laboratory is normally communicated on student's course outline and time table. Reminders can be sent by email, students' notice boards or on their mobile phones via social networks groups. According to Bristol and Zerwekh (2011:124), pre-contact preparation of nursing students involves giving them theoretical information of the procedure to be demonstrated, such as instructional notes, audio and video demonstrations via electronic learning programmes. Bristol and Zerwekh (2011) believe that pre-contact preparation allows the contact time to be used efficiently, with more focus on skills demonstrations, discussions and practice (Bristol and Zerwekh, 2011:124).

In this study there was no agreement amongst participants as to what constitutes best practice in the technique of demonstration of the procedure. It appeared that some preferred the demonstration of the whole procedure, while others preferred the demonstration of small components of the whole, before combining all the components in one demonstration. The researcher is of the opinion that these differences may be related to student's individual preferred learning styles. According to Felder and Brent (2013:60), learning style refers to the

individual's approach on how he takes in, organises and processes information depending on his strength and preferences. As a result some individuals prefer to process information in a step by step format, while others prefer to see the bigger picture before they can master the details (Felder and Brent, 2013:60). When considering differences in student learning styles, the researcher believes it could be effective to demonstrate the procedure as a whole, first to show the overview and then demonstrate it on small components allowing students to practice and master small components before they perform the whole procedure. The number of available clinical facilitator to student's ratio has an influence on the technique chosen to demonstrate a procedure and to the time available for student practice. In this study it was noted that dividing students into small groups would allow them more practice time and facilitate their learning. These students' perceptions are supported by the findings in a study by Bray (2014) on student views of their clinical learning experiences (Bray, 2014:30-34). Bray (2014), found that high student to facilitator ratio per clinical demonstration session is associated with poor learning outcomes, whilst small group teaching facilitates learning (Bray, 2014:30-34). The researcher believes that dividing students into small groups requires more clinical facilitators to facilitate the learning. Shortage of clinical facilitators is further facilitated by lack of working together between clinical facilitators from the hospital, registered nurses and the nurse educators. The clinical facilitators from the clinical facility, the registered nurses and the post graduate nursing students have not been invited for participation in the demonstration of basic nursing procedures in the Nursing Skills Laboratory, as this may increase the number of facilitators and allow for the small group facilitation and supervision.

5.1.2 Facilitation of clinical learning in the patient care areas

The findings of this study suggest a need to standardise the performance of procedures between the hospital and the nursing education institution, as this issue was a concern throughout all focus groups. It has been noted that there is discrepancy between how procedures are performed in the Nursing Skills Laboratory and within different wards in the clinical areas. Increased workloads coupled with shortage of staff are attributed as the reasons that lead nurses to take shortcuts when performing procedures (Magobe, Beukes and Muller, 2010). Lack of clinical equipment and other resources leads to improvisation and poor nursing practices and these shortcuts, together with improvised procedures, affects the quality of clinical learning (Msiska, Smith and Fawcett, 2014:38). Nursing students are left confused and lacking in confidence on the acquired skills because they learn procedures in a perfect world, which is a well-equipped Nursing Skills Laboratory, while being prepared for an imperfect poorly resourced clinical facility. Lack of keeping up to date with current evidence based clinical practices (by either nurse educators or registered nurses) can lead to such discrepancies in performance of procedures. The researcher believes that basic nursing skills should be demonstrated both in the Nursing Skills Laboratory and in the clinical area in real life situations. Nurse educators must discuss possible acceptable means of improvising and emphasise principles which ensure infection control and patient safety. Nursing students must learn to adapt and adjust to changes in the clinical area and know the standard in order to identify the diversion from the norm. Nursing students must always learn the rationale to performing each step in a procedure so as to be able to evaluate the level of compromise should the step be omitted or replaced due to improvisation. Registered nurses must always adhere to standards if challenges have led to diversion from standards, they should engage the students on understanding how they have

rearranged the procedure due to the situation; this will minimise confusion to a learning student and enhance critical thinking. The procedure files in hospital must include the acceptable methods of improvising should need arise, instead of only discussing items that are never available. Critical points should be noted in all procedures. The researcher believes it is the role of registered nurses in each ward to engage in research to evaluate the impact on patient care of all the resources used when improvising, in order to motivate buying of resources.

In this study, the presence of the nurse educators in the clinical area is advocated as a solution to confusion caused by lack of standardisation of procedures as well as for the nursing student's supportive needs on transferring skills learnt in the Nursing Skills Lab to real life situation. It was interesting to note that all nursing students, irrespective of the level of their training, verbalised a need for the support of nurse educators in the clinical areas and to be supervised. Supervision, support and positive feedback increases student's confidence in implementing nursing skills in real life situations (Houghton, Casey, Shaw and Murphy, 2012:1965). The nurse educator is seen as a guide, a confirmer of the attainment of intended learning goals. It is evident from the findings of this study that nurse educators must be closely involved in clinical teaching.

It is the researcher's opinion that the experienced discrepancy on what is demonstrated in the Nursing Skills Lab and what is observed in clinical practice lead to reality shock in the nursing students and mistrust towards the health care personnel who were observed performing the procedure. Consequently, the students are not receptive to learning. When students see a nurse educator and registered nurse together teaching the students, they will gain confidence in the registered nurse. There is a dire need for nurse educators to facilitate clinical teaching workshops for the registered nurses and clinical instructors who are involved in teaching

nursing students so that they are on par with what is expected from the students and how the procedures have been demonstrated in the Nursing Skills Lab.

The findings of this study advocate the need for effective communication between the university and the ward staff, as it has been noted as a facilitating factor for best practice clinical facilitation. This includes informing the ward staff that the nursing students are to be placed in the ward, including their objectives to be achieved during their placement. Lack of effective communication between the ward and the university staff includes having information directed to the unit manager and the failure of this person to disseminate the information to the registered nurses. Failure of the unit manager to add the nursing student in the off duty book affects the student's sense of being expected, especially those who commence in the unit during a weekend in the absence of a unit manager. Failure of the university nurse educator to communicate the learning objectives to the allocated students leads to lack of direction as to what is expected of them. The concern about ineffective communication is that it leads to the students feeling unwelcome and unaccepted and causes tension between nursing students and staff members, leading to another barrier to asking questions for learning. Nurse Managers are so busy in the unit they may easily forget to discuss the allocation of students with staff members, and so nurse educators must follow up to ensure a plan, for assisting students with their learning, has been put in place.

Nursing students suggest that they integrate theory to practice better when they are allocated in the clinical practice soon after being taught theory and having experienced simulation of the procedures to be performed in the clinical area. Lack of available clinical placements leads to competition for clinical placement areas and as a result, it is common to delay placement due to lack of available areas. It is the researcher's opinion that the challenge with this issue is

inconsistency of performance of procedures which leads to student's worrying that by the time they are placed in the ward they will have forgotten how the procedure was demonstrated in the Nursing Skills Lab. The researcher believes the students can re-read the theory behind the procedure but cannot repeat watching the demonstration. However if there is consistency in performance of procedures in the Nursing Skills Lab and in the clinical facility, the nursing student may observe and practice the procedure as it is done in the clinical facility.

Being allocated for at least a full day (12 hrs) per week has been suggested by the nursing students. The major barrier to this kind of allocation, is that the students would be required to attend other courses in the afternoon after six hours in the clinical area. The disadvantages of this is that students miss out on achieving completion of procedures that can only be done after lunch and in the morning the main goal of registered nurses is to cover their daily routines, meaning less time for assisting students. The researcher believes the most possible solution to ensure students achieve their objectives is for the nurse educator to be available during the six hours of their allocation so they can assess those who need to sign off their skills. They can also assist the students to achieve as much learning as possible during such short period of time.

5.1.3 Methods of learning

The findings of this study reveal a need to identify innovative methods of clinical teaching that enhance the socialisation of nursing students to their independent and interdependent role of a professional nurse. Nursing students suggested a need for nurses' grand rounds, where the nursing management is the focus of the discussion and they appreciate their experience of being part of multi-disciplinary discussion in a Mortality and Morbidity meeting. Many more teaching methods which facilitate such learning should be identified and be practiced.

5.2 CONCLUSIONS

The researcher understands from the participants that clinical facilitation is important to their growth in becoming competent registered nurses. With increased collaboration between the clinical areas and the universities training student nurses, in respect of planning, communicating and working together as a unit instead of two separate areas, clinical teaching can be improved and meet the needs of nursing students

5.3 RECOMMENDATIONS

5.3.1 Nursing education

Nurse educators, registered nurses, and clinical instructors from the nursing education institution and those from the clinical practice areas should purposefully work together to achieve best practice clinical facilitation of nursing students. This can be achieved through frequent meetings and clinical updates between all nursing educators and facilitator's involved in student teaching. During these meetings, challenges experienced by clinical facilitators on facilitation of nursing students can be discussed and solutions sought. Nursing educators will also develop a better understanding of the clinical areas and be able to integrate this in their classroom or Skills Lab teaching.

Clinical placements need to be well coordinated, taking into consideration the correlation of theory to practice and length of placements that ensures attainment of student's learning objectives.

Learning objectives should be communicated to nursing students, unit managers, clinical facilitators and registered nurses, in order to prepare them for their teaching and learning expectations. Nursing students should, if possible, be placed for a full day in clinical practicum

rather than half day placements in a week, so as to allow them to adjust in the environment and for the achievement of their learning goals.

Registered nurses who are devoted or interested in teaching nursing students during their clinical placements need to be identified and be acknowledged or rewarded, in order to reinforce their preceptorship roles. The nursing education institution could issue certificates of recognition and appreciation to those who effectively participate in clinical facilitation and to show appreciation for their preceptorship role.

Clinical education workshops, need to be conducted on an ongoing basis, aiming at revising clinical nursing procedures, to share knowledge between nurse educators and registered nurses. This intervention will ensure standardisation of procedures to evidenced based best practice and the standardisation in performance of procedures in both the nursing education institution and in clinical practice. This might have the added effect of encouraging registered nurses to teach in the clinical practicum, as they will feel supported and more involved in the student's development, plus improving the standard of clinical teaching.

Nursing grand rounds and other methods which encourage inter-disciplinary education should be encouraged; this could be achieved by scheduling them on particular days at certain times, thus encouraging participation by the university lecturers, clinical facilitator's and student nurses. It would ensure that nursing students identify the value of the nurse's role amongst other health care professional disciplines, as well as having the effect of communicating and collaborating amongst all educators involved in clinical facilitation.

5.3.2 Nursing Practice

Registered Nurses should create a positive learning environment through adherence to nursing standards in order to promote quality in clinical learning; should a need arise that they divert from the norm they should use it as a teaching opportunity in order to maintain trust with the student and prevent confusion.

Nursing management must ensure the availability of clinical equipment and other resources and nursing staff, including the nursing students, should be educated on cost containment in order to maintain the availability of resources and enhance effective clinical learning.

5.3.3 Nursing Research

Research on perceptions of registered nurses, clinical facilitators and the nursing students regarding best practice clinical facilitation of undergraduate nurses, would allow a view of the bigger picture about best practices in clinical facilitation.

A follow up research to review the success, failure or challenges on implementation of the above mentioned recommendations needs to be done.

5.4 LIMITATIONS

The setting of this study was one selected nursing education institution and an academic hospital where the participants were placed for their clinical practicum, therefore the findings of this study cannot be generalised to the perceptions of other nursing students in a different context.

5.5 CONCLUSION

The objective of this study was to determine what type of clinical facilitation undergraduate students believe should be offered by clinical facilitators in the clinical area, in order to best facilitate their learning. The findings of this study add knowledge to the nursing profession and education of student nurses with regard to understanding nursing student's perceptions of best practice facilitation of their clinical learning. The findings of this study will be able to guide educators and clinical instructors as to how best to enhance clinical teaching in the undergraduate student's clinical practicum, with the aim of producing competent and practice ready nurses on completion of their training.

APPENDIX 1: INTERVIEW GUIDE

CLINICAL FACILITATION: UNDERGRADUATE NURSES PERCEPTIONS OF BEST PRACTICE IN AN ACADEMIC HOSPITAL IN JOHANNESBURG

Estimated time :+/-40 minutes

Time	Activity	
00-05 minutes	• WELCOME • Introduction of members, • Aim of the interview,(YOU WERE SELECTED BECAUSE) • SIGNING OF CONSENT, • ground rules	Rules: Confidentiality. There are no wrong answers, feel free to speak out, all your ideas are very important. RESPECT OTHERS IDEAS EVEN WHEN WE DISAGREE WITH. CELLPHONES ON SILENCE.
05-10	Definition of terms	Clinical facilitation , best practice, CLINICAL PRACTICUM
10-30	Start questions	Probe, open ended questions, give others a chance to talk., keep checking if you receiving answers for your research question, control answers derailing from the topic.
30-35	CONCLUSION	THANK YOU, REFRESHMENTS TIME
IS THERE ANY OTHER THING……		

RESEARCH QUESTION: WHAT DO UNDERGRADUATE NURSES BELIEVE TO BE "BEST PRACTICE" REGARDING FACILITATION OF THEIR LEARNING IN AN ACADEMIC HOSPITAL?

RESEARCH OBJECTIVES: **What type of clinical facilitation undergraduate students believe should be offered by clinical facilitators in the clinical area in order to best facilitate their learning.**

INTERVIEW QUESTION: AS STUDENT NURSES WHAT DO YOU THINK CONSTITUTES BEST PRACTICE IN YOUR CLINICAL PRACTICUM EXPERIENCE WITH REGARD TO CLINICAL FACILITATION?

Think back on your experience you may have had in your clinical practicum….

- IF YOU WERE SURE ALL YOU ASK WILL BE GRANTED, WHAT WOULD YOU ASK CLINICAL FACILITATORS TO DO TO ENSURE "BEST PRACTICE" CLINICAL FACILITATION?

Probes: what made it best? How did it assist your learning? Tell me more, why do you say so? Is there any other thing you consider best practice in your clinical learning that we did not talk about?

TERMS DEFINED

BEST PRACTICE is the best and the most effective way to do something. “It may also be a working method or set of working methods that are ... noted as the best to use.

CLINICAL FACILITATION is helping students individually or in groups to work effectively to achieve their learning outcomes. It involves but not limited to planning learning activities, using teaching methods that may stimulate and support their learning, guiding students to new meanings and understanding.

CLINICAL PRACTICUM IS: a relatively safe environment where students can learn and develop clinical nursing skills in a real life situation under the guidance of an experienced professional.

.....

APPENDIX 2: INFORMATION LETTER

CLINICAL FACILITATION: UNDERGRADUATE NURSES PERCEPTIONS OF BEST PRACTICE IN AN ACADEMIC HOSPITAL IN JOHANNESBURG

Hello

My name is Sabelile Tenza; I am a student at the University of the Witwatersrand, studying for Master of Science Degree in Nursing Education. As part of the course requirements I am expected to conduct a research under supervision.

A Research is a step by step guided and controlled procedure that is used in order to find answers to the questions. In this research I want to find answers on: **What do undergraduate nurses believe is best practice with regard to clinical facilitation?**

The purpose of this research is to explore and describe the perceptions of undergraduate nursing students, regarding the best practice of clinical facilitation of their learning, in their clinical practice.

I am **inviting** you to take part in this study.

What is involved in the study: You will be invited to join a focus group interview. This means that you will be interviewed as a group of students of the same level of training. There may be 6-10 members of other nursing students, e.g. other second year students if you are at second year of your training. Every participant's views will be considered very important, and will not be used against the participant. It will take you about 30 to 40 minutes to be in this focus group interview. A researcher will facilitate the focus group interview; there will be a co- facilitator who will assist with notes taking.

Risks: Participating or not participating in this study will not influence and will not affect your academic results. There will be no risks attached to participation or not participation.

Participation is entirely voluntary, and you are allowed to withdraw at any time should you wish do so, no penalty will be charged to you.

Confidentiality and Anonymity will be encouraged by the researcher, as you will be asked not to discuss what people said in the focus group outside of the group. Absolute confidentiality cannot be guaranteed. If a direct quote is made of anything you said in the report, this will be done anonymously, without mentioning your name.

Benefits: No clear benefit will be derived to you but that the findings of the study will be made available to you on completion.

Please feel free to ask me any questions you may have so that you are clear about what is expected of you. Should you agree on participating, please kindly sign the attached consent form.

Approval and permission to do the study has been obtained from Human Research Ethics Committee (Medical), and from the Post graduate Research committee of the University of the Witwatersrand.

You may call **Human Research Ethics Committee administrator and chair** – on this number (011)717-1252 for reporting of any complaints / problems relating to this study, or if you would like to understand anything relating to your safety while participating in the study.

Name and contact numbers:

Researcher: Sabelile Tenza (071-6878552)
Supervisor: Mrs. Hilary Thurling (011-488 4269)
Co-Supervisor: Dr. Sue Armstrong (011-488 3094)

APPENDIX 3: CONSENT FORMS

(1) CONSENT TO PARTICIPATE IN THIS STUDY

I……., have read and understood the information on the information letter of this study. I have been informed about the purpose of the study. I willingly agree and give consent to participate in the study, which aims to describe the perceptions of undergraduate nursing students, regarding the best practice of clinical facilitation of their learning.

I understand that consent is voluntary and that I may withdraw from the research study at any time with no penalty to myself. I understand that if anything I have said during the focus group is used as a direct quote in the report, this will be done anonymously and I agree to this. I understand that I will be given a copy of the research findings should I wish to have a copy.

Signature of the participant:……

Date: …….

(2) CONSENT TO DIGITAL RECORDING

PERMISSION TO DIGITAL RECORDING

Dear Participant

I would like to request your permission to digital recording of the focus group interview that will be conducted with you. Your real name will not be used in the interview and these records will not be given to anyone other than those involved in the study. I will destroy these records once they are no longer required to be used in this study.

Thank you
I.S.Tenza (Cell no: 0716878552)
MSc. Nursing Education (student)
Department of Nursing Education
University of Witwatersrand

CONSENT TO DIGITAL RECORDING

I ……., consent to be interviewed and I understand that this interview will be recorded for the sake of accuracy and reliability. I understand that the consent is voluntary and that once these records are completed its use towards this research, they shall be destroyed.

Participant signature: ……. Date:……

APPENDIX 4 : PART OF TRANSCRIBED DATA

CLINICAL FACILITATION: UNDERGRADUATE NURSES PERCEPTIONS OF BEST PRACTICE IN AN ACADEMIC HOSPITAL IN JOHANNESBURG

Focus group interview: Day 1 Duration : 1 hour

2nd years

Date: 8/05/14

I: Interviewer

P: Participant

C: Co- Facilitator

I -Good morning everyone

P – Morning .

I: My name is Sabelile you all know me, you know your colleagues, Hilary is my co- facilitator. We are here today to do a focus group interview so we can collect data under the topic of "clinical facilitation, Undergraduate nurses perceptions of the best in the academic hospital in Johannesburg" .

- You all have consent form in front of you, thank you for coming.
- You were selected because we know that you've done your first year and are now in second year and from your experiences you will be able to give us that rich information we hoping for, towards this study.

- I would like all of us to switch off our cell phones. Be free when you are talking, don't think that you will have an information that is not valuable, will we respect one another , co-operate, and give everyone a chance to speak and don't think your idea will be undermined even if it is against some ideas that are coming up there is no right or wrong answer. It's not an exam, we are just here to talk and get information.

I am going to start with explaining some terms that are going to appear on the question that is on this interview.

The interview question says:

As nursing students what do you think constitutes best practise in your clinical practicum experience with regard to clinical facilitation?

It's there at the bottom of this page entitled definition of terms. So, there are 3 key concepts or terms that I thought it will be better for us to understand.

1. Best practice: is the better way of doing something ,the effective way to do something, the method that work better ,it is the set of working methods that are noted as best to use, it constitute the action and ideas that represent the most effective, efficient or prudent course of action

2. Clinical facilitation: Is helping students individually or in groups to work effectively to achieve their learning outcomes, it involves but not limited to planning learning activities using teaching methods that may stimulate and support their learning ,guiding students to new meanings and understanding. Its aiming is to assist students to integrate theory practice.

3. In this question, the word clinical practicum, refer as to the relatively safe environment where students can learn and develop clinical skills in a real life situation where you do your practicals under the guidance of an experienced professional nurse.

So, we are going to start, I'm going to just ask a question, anyone can start giving me the answer of what he thinks.

I'm starting.....

I: As student nurses what do you think constitutes best practise in your clinical practicum experience with regard to clinical facilitation? You may ask if you do not understand a question.

P1: Yes, can you clarify that as to uh..m ,our answer is it like base on what do we think of the way our clinical facilitation has to be conducted or what?

I: We looking at clinical facilitation. The best practise in clinical facilitation, this that when you looking at it being done by the registered nurse who is supervising your work, who is paired with you in your clinical practice or your nurse educator who are from the nursing department when they visit you in hospital, supervise you, What is it that when they did, you thought like, " that's best practice"? You can think that from your experience from first year until now.

P2: I think best practise is demonstrating to the students and explaining the procedure clearly, that's what I think its best practise.

I: ok, you saying it's explaining the procedures to students. OK, anyone else.....

P3: When I was working in 496, the sister will give you homework, said we should go and read on hypothyroidism, and hyperthyroidism you come up with ways to get the patient better. And there was this other condition the patient did not look that sick, and had signs and symptoms that we did not recognise until we did the homework because the patient looked normal ,I found that very helpful.

I: thank you, anyone?

P1: I think there is no congruency between what we've been taught in our Dem room and what we get to experience in the wards, you know. because take that for example you have a specific skill you need to perform in order to qualify for you to do your OSCE so you need to go to hospital and ask the sister that you would like to perform a skill and ask her to sign for you, so what happens is that you get there .....and you want to do it the way you've been taught to do it because that is the right way to do it, but that's not how it's been done in the hospital setting itself. So, for me I thought that it's, like it will be better if we were being assessed by people who are teaching us on those skills rather than being sent to the hospital and like go and perform your skills and have them signed, you know. So what prevent the students to get them signed off without doing procedures? So, I think one thing they need to look at because there is no real correlation between what you are taught in the Dem room and what we do in the hospital itself because if it was the same thing there wouldn't be a need for coming back to practise our skills before OSCE .So, now you have to come back and repractise because that's not what is being done in the hospital, as much as you try to do it but sometimes there are no equipment for you to do the procedure correctly or thing like solution maybe you do not have solutions for wound irrigation you know ,you do not have equipment from the CSSD and they teach you that you need to put things like the arterial forceps that you need to put in the biotain whereas it's something that we were told that it was not right in the Dem room.

P4: (another participant adding) you have to improvise in the hospital.

I: Ok, I hear you. You mentioned something say you are supposed to sign your skills or being evaluated on your skill in hospital by the person who is not the one who taught you the skill in the Dem room .So, can you link that to what you perceive as best practise.

P1: Well what would be best practice is, if we had maybe those specific sisters in the hospital, those specific sisters in the hospital would come for training for those skills in the Department, yes they know them but probable they have done that ages ago and now only they are working on just experience and we still upcoming, we need to know the rationale behind the doing, on performing certain skills. But I think it will be nicer if we had like a specific sister that is in charge of those skills in that ward so for instance we doing wound dressing or Suturing so we know that for that procedure we going to a specific ward and because there is a specific sister who were on the training that was conducted by the department, who knows what is expected from them and what is it that they need to look for when they assess you and so for me that will really mean that we have best practice. Because as much as we try to be competent but ……(interrupted by another participant)

P5: Rita and Lizelle did say that they can come up, you just need to make an appointment.

P4: There is many of us and few of them.

P4: It would be good to have someone in hospital rather than having to call them every time because they also have things to do.

P6: Other problem is that, we as students studying and we go work in the hospital which got nothing to do with wits. I'm not sure if it's the nurse's job to teach students……..this is something that I don't understand as a nurse in an academic hospital is it your job to teach the students?

I: Yes it is.

P6: Is it an unset rule or?

I: It's a requirement by SANC.

I: Ok, you seem to have something more to say.

P1: Yes, but.....also to talk about the link between exposure the time to our clinical practice, you know when you go to the ward you find that we are placed from 7 to 1pm I mean you really cannot learn much from 7 to 1pm, you really cannot learn much and what happens is that you have 4days in a month to go to that specific ward for six hours per day and you get there.....

What happens is, in second year they expect us to know our patients and what is happening with the patient ,what the conditions are they having, you know, this type of a thing ,So if we have enough exposure, may be we know that on Tuesday we work seven to seven and we get enough exposure ,when you get in the morning and you get to be allocated to do observations and to do cardex and sometimes you don't even have time to actually perform skills and all that ,so I feel that for something to be regarded as achieved best practice it would be good if we had more exposure .

I: OK, would you like to say anything?

On your experience of your clinical placement ,what is it that when the nurses where teaching you, or your clinical facilitators from the department or your clinical facilitators in the hospital, what is it that they did or they are doing that you considered best 77ractice?

P5: The personality, easy to approach, interested in showing you around and show interest in us, in some wards you find them, sometime you find them unapproachable, it takes a while to warm up and get them to like you, I found that every ward is different.

P1: But what I like about our clinical facilitation is, when you have theory that you can link to practice so they explain what it means theoretically, then when you perform the skills you get to understand them better. So, it's much easier that way.....but what is not so good is like sometime they fast forward like the practice of skills and if you 77ractice77z skills you need to be sure that you doing it correctly....not the (maybe I have done that and that ,I've already washed my hands ... Ok Mr so and so what would you do next,) for me it's not a skill its more talking, you know, and you actually not learning much from that, every skill like if you watch the Stellenbosch for the videos for their skills, the facilitator makes it so real , would walk in and say hello Mrs ....., I'm a nursing student I'm assigned to nurse you today, she does the whole procedure, it becomes so real , not the would have , would have washed my hands.....for instance, only after she is finished the students are assessing their facilitator.

P4: Another thing in the ward it's different, you know how we talk to the patient, it's not what we observe when we get there. Like how we taught to keep communicating to the patient, but they don't

do that in the ward.

P2: I liked it in 496, we did the ward round with the sister, and that helped you to see all the patients, which was nice I liked it.

I: Ok, anything?

P3: It also help when a sister knows what she is talking about ,sometimes the nurses who have been in the ward for like three years you would expect them to know the conditions and you ask them because you don't know the conditions, and you say sister I do not know what this means ,they will say uh..m I don't really know ,like you should know if you been there for at least 3 years, I mean it helps when someone know and they can share information back, you know..

I: Ok, thank you.

P5: when I worked there in December I worked in 595 for 3 weeks, I think .....we had more time to be exposed to the conditions because sister gave us a list of conditions. And said at least in one day at least you are asked to do two conditions to present in the ward, the Sister would leave us to explain everything to ourselves, you learn about a condition and then you learn to manage it yourself, you get to learn everything.

You can do this and that ,like she let us do everything for ourselves and she will tell you, you see that patient today you are nursing that patient only, learn about this condition.....like .....it's more like you are managing a patient alone ,it's your patient ,you know everything about the patient and what's going on with that patient then they give you another patient and you just go through a patient, and then when I was done ...in that ward I felt that I've learnt a lot in this ward and she will ask us which skills have you done, do you know how to do this . She will take you go and do that skill and then she will tell you what you didn't do and what you suppose to do and why? She would not allow you to use the automatic machine but only to use the manual.

P6: I will just touch on uh..m.. it's like when we go to the wards we going there to sign of our time of being there that's not supposed to be the case , what I like in this other ward, Sr..... I forgot her name but she would assign you for that particular ward...she will assign you to do medication.....with another professional sister but she would ask you to go learn about the medications they use in that ward, then the following day you give a formal presentation to the whole nursing staff, and it makes you feel that you know what is going on in the ward. The sister in charge in cardiac ward will call us to the office then she talks to us for maybe 30 minutes, ask us to reflect on what you learnt from that ward so, I think like the sisters in that ward assist and they encourage us to actually learn about the

conditions of that particular area to know what they are having and make sure by the time you live the ward there is something that you know about the cardiothoracic ward.

P2: I liked it in other wards there is in formation in the wall, on posters about the conditions that they nurse, you can actually write it down.

P3: The information on the wall , what you gonna do there is no balance people just do things because they have to. Posters being there that's not enough there should be people who know and who can teach if they won't teach and it's like there are few people who know what they are doing and they also don't have time.

I: That is very interesting so, when you take that, that you say and put it in the context of what we talking about what will best practice, be?

P3: Best practice will be, I think those people who work in that area should know what is in the posters and educate people who come there, because when you are in the ward you are ready to learn as you want to know more about the conditions that you don't understand.

I: Ok.

P1: So like, in oncology ward what is nice about is like there is a flow chart with normal values, that means you required to have list of normal ranges so that you can be able to interpret results of the patient's blood. The doctors will write the results on a flow chart, you are expected to interpret the results. Like Increased bilirubin, that helps us to integrate normal physiology to pathophysiology, so it encourages your thinking so that you know what you were taught, so I wish it was like that, in all the other wards if you could be able to interpret what is going on with those patient conditions.

I: So, where is the gap?

P1: I think if in every ward you may have a chance do that , if we are able to interpret and think that's why that patient blood would decrease so you know why, linking to the pathophysiology that you learnt in the nursing theory rather than just thinking that is for Doctors.

I: So in this particular ward they ask you to do it or they encourage you to do it, or they task you to do

it.

P1: Yes, for somebody who is assigned to do observations in that day and you note that ,that patient's blood pressure is low or the saturations is that much , then you have to interpret what is the underlying pathophysiology.....or their red blood cells are that much you need to be able to interpret why that has happened .

I: OK, I just want to make sure that I'm hearing you well.

P7: Yes, and that helps you to actually think the best nursing care plan for that patient.

P8: Sister, another thing that is not best practice is writing of Cardex, they always say. Patient had a slept well, ...patient was bathed.....,medication was given., when you check the notes says the temperature was 36.6 and when you check where is the thermometer , there is no thermometer.

P4: Ja, it's what was discussed the other day in the ward about the writing of cardexes that when you write cardex tell the truth of what happened.

I: OK, I'm just going to ask the same question but just in a different way.

If you were sure that all you ask will be granted what would you ask clinical facilitator to do to ensure "best practice" clinical facilitation?

If your request was going to be granted and you were going to give a recipe to best 80ractice clinical facilitation, what would you ask for?

P4: I know what I want.

I: what do you want?

P: like what the doctors do come to the ward with the whole team of doctors, and the one who teach them, they go from one bed to the other, discussing the patient problems and their plan of care and management. If we could have that from the nurse's point of view, we go bed to bed, discussing the patient management and how it could be done better, not reading the BP120/65 and slept well.

I: OK, so you request the Nurses Round that is not a handover, discussion of care.

P8: yes.

I: OK, give us your recipe.

P7: no I don't have.

I: Well, No recipe, no request, Ok, the request will be granted.

P7: More hours, yes for us to be in the wards. Have a sister who would teach us in the ward.

I: During practice time?

P7: Yes

P6: More hours.

P2: with the skills for the Dem room, if we may be given notes first, show the demonstration later, like what Lizelle did when she taught us on suturing, like give lecture first, demonstrate and then video to re-in force what we learnt.

I: Ok,

P4: and also to learn how to do Cardex properly.

I: ok, I just want to repeat the question again so that we don't lose track. I just said, if you were sure all you ask will be granted, what would you ask clinical facilitators to do to ensure "best Practice" clinical facilitation?

P4: Ok.....I will just say as my colleague requested that we have nurses round where we actually have chances to share and hear other people's views and ideas and gain knowledge on patient care.

P1: Yeah! .uh..m As student actually, the first one is just to emphasize what they were saying, where we will have the round like doctors they come to that ward ,to that specific ward with their facilitator ,their head of the department that they move from bed to bed and move from one to another cubicle, So not only the nurses who are working in that area because I mean mostly in first year what was important was to know giving bedpans, but now what happens is that you need to understand what is happening with that patient, it's about understanding the physiology so ,if we are like now , not everyone can be allocated to the same ward with the conditions we doing in class at the same time, like respiratory ward. And you get to be allocated to respiratory ward later in a year or even before or may be sometimes you already forgot the thing.

I: Ok, what is the problem, are there no wards?

P1: There are no enough wards, can be so many people that are placed in one ward at a time because there is like 24 of us ,and we can't all go there and work there ,So it would be nice if we had like .....like what we did in oncology department. We all went there and we were able to engage with patient and for me that was like something.

And another thing, this signing off of skills in the hospital ,like I really don't understand ,like why....we have to do it why we have to have skills signed off in the hospital ,it will be nice if there was an explanation to that, as to why it is supposed to be done that way like you know. To have skills signed off it will really be nice to know because we going there and you need to ask to have skills signed off just for the sake of qualifying to go to the OSCE. And we struggle to have skills signed off just before OSCE. Sometimes you are not allocated to the wards where skills are done.

I: what makes it difficult?

P3: its stress and we don't have time and sometimes you are allocated there or you are allocated on 2 wards that don't cater for those skills.

Most of the participants: Yeah!.....it is stress.

P5: And sometimes in the wards, I had a chance to wound irrigation and it's only the Ens in that ward

who is allowed to do it .you remember the sister that she said she trust the permanent staff to do the right thing you know, so we need to have those skills but we can't because there are specific people assigned to do that.

P6: They couldn't allow you to do the procedure in the presence of this experienced EN.

P1: yes they won't allow.

I: Reason?

P4: The reason being .....one, was that you can't open the wound because the Dr said the wound should not be opened.

I: when the doctor prescribed to say it can be opened?

P5: Yes, and when it is prescribed they open but you cannot do the dressing. They also have a wound specialist who is responsible for that, but she would say that she entrust the permanent staff to do that type of work. And also within this six hour of your placement no one cares about you doing a skill, before you even think of a skill your time is up, because you have been busy with the other tasks that you were allocated for.

I: Do you think six hours of your allocation it's an issue to make you not be allowed to do the skills?

P7: Yes, because they say you guys are here for six hours so you'll have to do this and that, and at 12:30 you have to go.

P8: I agree you do observations and can't even think about the skills.

I: what happens after 12:30.....?

All: we have a class, so we have to leave.

I: So what would you like to see happening about that we discussed?

P1: about uh...m having skills signed off?

I: Yes

P1: I think like it will be nice if we are allowed specific time to do those skills like it shouldn't be integrated into our work time.

I: Because in my opinion I would think when you are allowed to sign skills in clinical area it's so that you not limited, you have more opportunities that the registered nurse who have supervised your demonstration of the skill is allowed to sign it. I think in that way it says there are more opportunities than when it waits to be done in the Dem room.

P1: Yes I agree, I'm not saying that it shouldn't be done at all, but that if we allocated may be like in a month we have 4 Tuesdays that we have to work, and if you have four Tuesdays to work maybe we have one Tuesday that we know that maybe 10 people are going to do 1,2,3 skills in a specific ward, so we notify the ward that 10 people are going to come on that Tuesday for 6hours for those skills only so that they know in that ward that they don't have to do those procedures because they know they are going to be done by students and need to assess them, because they can't attend all of us ,maybe 5 on that specific Tuesday go and the nurses are informed about that .its impractical you know because we have a lot to do because sometime we have to run to the pharmacy to collect that and be sent to the tunnel, so we don't have actual time to have our skills signed off in the hospital .So it will be better if we have that one Tuesday maybe for instance where we just go there for the skills e.g wound irrigation and dressing or ECG only and not actually to work.

I: Ok

P1: And then the last one is like our Dem room, I don't think is stimulating enough, its old and it doesn't have enough equipment , no gloves ,sometime you know you get there and there are not enough resources like that time we did female 84ractice84zation we had to ask from the hospital. So I think like the equipment in our Dem room need to be looked at, and mannequins are also old and are not stimulating anymore for you to want to be at the Dem room ,it doesn't create that real life situation anymore ,it doesn't also because that. Yes I see the have bought Sim Man, I know they are very expensive; it would be nice to have more. They are not stimulating anymore, you know, some are torn. It would nice to have good equipment to learn better and facilitate learning.

I: Ok,let me read it again (if you were sure all you as will be granted, what would you ask clinical facilitators to do, this include clinical facilitators, registered nurses, educators who are facilitating you clinically ,what would you like them to do to ensure best 84ractice clinical facilitation.

P7: I think, there's too many of us, I think I would like us to be divided, because most of the time when you get there and there is so many of you. It is overcrowded you can't even do skills or have enough time or chance to practice, it would be better to work in groups. Sometimes there are two people who get to do a skill and you don't get to practice on the skill and then the next time it's a different skill so you don't even get time to practice it on the mannequin the next thing you have to do it in the ward. So, it's better to divide us in groups just like those for PBL. Overcrowding makes you then lose concentration and don't do anything.

I: I consider what you say, what happens if, you make private time for coming for practice on your own private allocated time?

P3: The private allocated time,…… it means that for that 3 hours that you allocated in the time table you really going to waste because most of the time we don't 85ractice ,we don't do anything when you get into a Dem room, you watch the skill then you talk.

(some participants):THAT'S TRUE!

So we rather have a division ,instead of us having everyone going to PBL same time , its better they divide us , as they divide our PBL group it will be nice to divide our clinical as well.

I: OK

P7: And the learning in the Dem room it's not directive ,there is no structure ,like when you get there this is going to happen, ……..it's just that ,ok is everyone here, Ok…now we gonna do this. We have already, cleaned the trolley…. We've already…there is no structure; you like I wonder what are we going to do today. It's not really what you know like for instance you know that today we will have a lecture, then demonstration, later get the feedback.

I: what do you mean by feedback?

P1: Like feedback as in, on that skill if it is was done properly, how did you do, how to improve on it. Why are you doing it? And you get confused, I get confused.

I: Just tell me more about what would you like to see happening.

P3: Ok, before you get to the Dem room, it's good that we have paper telling you which skills that you gonna do before we get to the class, that's good and you get there you know you gonna have a lecture. And then after the lecture its better you do the skill, do the whole skill with no one distracting or asking questions ,or comments, do the skill completely and talk later about the skill. Because once you have questions some one answer , or comment.....in between, that's why people get confused and that's where people have comments, That's where people talk and then they lose focus ,and pattern of the steps of the skills.

P1: An ideal clinical facilitator must go like .....Hi Mrs ....im student nurse so and so, I'm assigned to look after you, ..., not the would have ,I would have washed my hands, I would have , I would have used a crepe bandage..... if there was ....., NO would have . Bring the real life situation.

It must be a more real situation, because it really get confusing even during the OSCE you not sure what to do, I would have washed my hands; I would have cleaned the trolley.

P4: I just can't watch Rita washing hands 3 times every procedure.

P1: But it will be confusing in the OSCE. Rita also get lost with explaining and answering questions.

P5: I get confused if I don't always have to wash my hands.

I: let's give her a chance, she is the last one.

P6: if we can be allowed to request what we want to do in the ward, specifically that which you want to practice , it is sometimes so boring to be allocated to do one thing all the time in the ward that's where I begin to lie because it is Cardex again..

I: ok ladies and Gentlemen with all that you've just said, is there any specific teaching methods relatively to clinical facilitation or clinical teaching, remember when we talking about clinical teaching we are talking about the teaching that happen to ensure that you learn your clinical skills, is there any teaching method that really you considered it best to enforce your skills?

P1: Yes Uhm... I'm not bragging but I used to be a paramedic before I change to nursing and what we

used to do was during our clinical skills, uhm what we will do was, we would form like some sort of a PBL but not a writing type of PBL what we used to do was as you walk in they would give you a scenario about that patient, the skills that you have to perform,

There is a setup of the things you will need……..so now you have an idea of why would you need this for that patient. So as you walk in they give you a scenario of that patient that maybe Mrs so and so has fainted what is the first thing you need to do so now you need to know your theory and it gets you thinking, and its good in that you know when you check those things you are able to link the skills as well with the conditions you will be having.

So maybe there is something like uhm. Mrs Downs, she has a gangrenous leg. And then when you see that as you come in and you know that ok this is my patient, I need to wash my hands and you talk to her and you ask her for her history, you know it gets so interactive, rather than when we know that we coming for one skill from that patient.

I: so it's an integrated skill?

I: Ok, anything you found best even in your experience that really left you saying I've been taught skills but this one was really best practice.

P7: if students can be grouped six or seven to study patients conditions in the wards and analyse care and come and feedback to a meeting with the rest of the group.

I: thank you very much to everyone for such a wonderful input. Thanks for your time as well.

All: Pleasure.

……

APPENDIX 5: PERMISSION FROM HUMAN RESEARCH ETHICS COMMITTEE

R14/49 Ms IS Tenza

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M140382

NAME: (Principal Investigator)	Ms IS Tenza
DEPARTMENT:	Nursing Education Charlotte Maxeke Johannesburg Academic Hospital
PROJECT TITLE:	Clinical Facilitation Undergraduate Nurses Perceptions of Best Practice in an Academic Hospital in Johannesburg
DATE CONSIDERED:	28/03/2014
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Mrs Hilary Thurling
APPROVED BY:	Professor P Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	12/01/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX 6: PERMISSION FROM HEAD OF THE NURSING DEPARTMENT

House No. 9

Casa TheunisKraal

20 Theunis street

Weltevreden Park

15/04/2014

Head of Nursing Department

University of the Witwatersrand

Department of Nursing Education

7 York Road

Parktown

REQUEST TO INVITE STUDENTS TO PARTICIPATE IN THE STUDY

Dear Professor Maree

My name is Immaculate Sabelile Tenza, I am a student at the University of the Witwatersrand, studying for the Master of Science in Nursing Education. My supervisors are Hilary Thurling, and Dr Sue Armstrong.

I would like to request a permission to invite second, third and fourth year nursing students from the University of the Witwatersrand Nursing Department, to voluntarily participate on focus group interviews for the research study entitled: CLINICAL FACILITATION: UNDERGRADUATE NURSES PERCEPTIONS OF BEST PRACTICE IN AN ACADEMIC HOSPITAL IN JOHANNESBURG.

The *purpose* of the study is to explore and describe the perceptions of the undergraduate nursing students regarding the clinical facilitation best practice. Focus group interviews will be conducted at a time and place convenient to the students.

Information letter will be given to the students, with an opportunity for them to ask any questions of the process and reason or conducting the study, if they should chose to

participate then voluntary informed written permission will be requested, for participation and for digital recording of the interviews. Approval and permission to do the study has been obtained from Human Research Ethics Committee (Medical) Number M1140382, and from the Post graduate Research committee of the University of the Witwatersrand.

If you would like to see the full proposal I will deliver it to your office.

Yours sincerely

I.S. Tenza (Cell No.: 0716878552)

sabelie@yahoo.com

……

PERMISSION FROM HEAD OF THE NURSING DEPARTMENT (COPIED FROM EMAILS)

On Wednesday, April 16, 2014 3:05 PM, Lize Maree <Lize.Maree@wits.ac.za> wrote:

Dear Immaculate

Thank you for the letter introducing your study. You are most welcome to invite the undergraduate students to participate in your study once you have ethical clearance.

Kind regards



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