

**WORK INTEGRATED LEARNING EXPERIENCES OF PRIMARY HEALTH
CARE POST BASIC NURSING STUDENTS IN CLINICAL SETTINGS**

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

Signature of student

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Abstract

Background

Work Integrated Learning is an educational approach that aligns academic and workplace practices for the mutual benefit of students and workplaces. Work Integrated Learning like in any other nursing course is essential in primary health care as required by the South African Nursing Council. In the clinical setting, students develop clinical and diagnostic reasoning; they also learn how to make the appropriate clinical decisions which they need as qualified primary health care practitioners. This is achieved through instruction and guidance by lecturers, mentors and clinical staff. However it has been noted that the clinical learning environment confronts students with challenges that are absent from the classroom situation. So this study seeks to explore and describe the experiences of post basic nursing students in primary health care clinics so as to address the challenges that are faced within the clinical settings.

Aim of the study

The aim of the study was to explore and describe primary health care post basic nursing students' experiences during clinical placements.

Methodology

A descriptive exploratory qualitative approach was used to guide the study. In-depth interviews were conducted with ten primary health care post basic nursing students who were allocated for Work Integrated Learning at the clinics in District A and District B in 2011. The main research question for this study was asked: 'What are the experiences of primary health care post basic nursing students regarding Work Integrated Learning?'

Results

The findings of this study revealed that Work Integrated Learning is vital for the development of clinical skills amongst primary health care post basic nursing students. However, shortage of staff, inadequate material/ non-human resources, lack of supervision in the clinical facilities, distant clinical facilities and insufficient practice in the clinical skills laboratory were identified as challenges that students experience during Work Integrated Learning placement.

Dedication

I dedicate this dissertation to my Mum, my husband, my twins and my niece for their endless support and encouragement of my studies. Without them it would not have been possible for me to complete this study.

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Glossary of terms

Clinical accompaniment: A structured process by a Nursing Education Institution to facilitate assistance and support to the student nurse education in a clinical facility to ensure the achievement of the programme outcome (SANC 2011: 1).

Clinical facility: A health facility whose primary purpose is the provision of care to patients and is also used to teach clinical skills to learners and students (SANC 2011: 1).

Clinical supervision: The assistance and support extended to the student by the professional nurse or midwife in a clinical facility with an aim of developing a competent, independent practitioner (SANC 2011: 1).

Competence: Knowledge, skills and attitudes that enable an individual to perform a role or a task up to a defined level (Uys 2003: 29).

Council for Higher Education: An independent statutory body established by the Higher education Act, no.101 Of 1997. The CHE is the quality Council for Higher Education, advises the Minister of Education and Training on all higher

education issues and is responsible for quality assurance and promotion through Higher Education Quality Committee (CHE 2011).

Mentor: A registered nurse who is trained and registered with SANC in Clinical Nursing Science, Health Assessment, Treatment and Care (R48) and has signed a mentoring agreement with the university under study to support and guide PHC post basic nursing students in the clinical facility.

PHCI: Students registered for first year in Clinical Nursing Science, Health Assessment, Treatment and Care (R48) at the university under study.

PHCII: Students registered for second year in Clinical Nursing Science, Health Assessment, Treatment and Care (R48) at the university under study.

Preceptor: Is an experienced practitioner who teaches, instructs, supervises and serves as a role model for a student or graduate nurse, for a set period of time in a formalised programme (Mills, Francis & Bonner 2005: 5).

Preceptorship: Is a method of preparation for practice, utilizing clinical staff opposed from faculty staff that provides supervision and clinical instruction to new practitioners, undergraduates, newly registered or new to a specific clinical environment (Mills, Francis & Bonner 2005: 5).

Primary Health Care: The essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (Dennill, King & Swanepoel 1999: 2).

Primary Health Care post basic nursing students: A group of students that are qualified Registered Nurses enrolled for a post basic programme in Clinical Nursing Science, Health Assessments, Treatment and Care. In this study it refers to a group of first and second year students that were registered for a programme, Clinical Nursing Science, Health Assessment, Treatment and Care in 2011 at the university where the study took place.

Registered nurse: A person registered with the SANC as a nurse under Article 16 of *Nursing Act, No 33 of 2005*, as amended (Republic of South Africa 2005). The terms 'registered nurse' and 'professional nurse' are used interchangeably.

South African Nursing Council: The body entrusted to set and maintain standards of nursing education and practice in the Republic of South Africa. It is an autonomous, financially independent, statutory body, initially established by the Nursing Act, No. 45 of 1944, and currently by the Nursing Act, No. 50 of 1978 as amended (Republic of South Africa 2005).

Trained nurse: A registered nurse trained and registered with SANC in Clinical Nursing Science, Health Assessment, Treatment and Care (R48).

Work integrated learning: An approach to career-focused education that includes classroom-based and workplace-based forms of learning that are appropriate for the professional qualification. WIL aligns academic and workplace practices for the mutual benefit of students and workplaces and it should be demonstrably be appropriate for the qualification concerned (CHE 2011: 4).

List of acronyms

Acronym	Full word
AHPRA	Australian Health Practitioner Regulatory Agency
ANMC	Australian Nursing and Midwifery Council
CHC	Community Health Centre
CHE	Council on Higher Education
CNAC	Canadian Nursing Advisory Council
COPC	Community Oriented Primary Health Care
CPAS	College Principals and Academic Staff
CWHs	Community Health Workers
DENOSA	Democratic Nursing Association of South Africa
DHS	District Health System
EDL	Essential Drug List
FUNDISA	Forum of University Nursing Deans in South Africa
ICN	Intensive Care Nursing
KZN	KwaZulu-Natal
MDGs	Millennium Development Goals
NCNZ	Nursing Council of New Zealand
NDoH	National Department of Health
NEA	Nursing Education Association
NEI	Nursing Education Institution
NHI	National Health Insurance
NMBA	Nursing and Midwifery Board of Australia
NMC	Nursing and Midwifery Council
NQF	National Qualifications Framework
OSD	Occupation Specific Dispensation
PHC	Primary Health Care
PHEPSA	Private Health Education Providers of South Africa
PPE	Positive Practice Environment
RDP	Reconstruction and Development Programme
SANC	South African Nursing Council
SAQA	South African Qualification Authority
SNC	Swaziland Nursing Council
WHO	World Health Organisation
WIL	Work Integrated Learning

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

Primary Health Care (PHC) as an ideal model of health care was adopted in the declaration of the International Conference on Primary Health Care held in Alma Ata in 1978 (known as the "Alma Ata Declaration"), and became a core concept of the World Health Organization's (WHO) goal of *Health for all* (WHO, 1978). The PHC philosophy introduced at this conference was endorsed with enthusiasm by participating nations (Dennil, King & Swanepoel 1999: 2). PHC has been globally accepted as an appropriate strategy for universal coverage of essential health care on equitable basis and accessible at an affordable cost (WHO, 1978).

PHC is essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals at an affordable cost (Dennill, King & Swanepoel 1999: 2). It provides immediate and often continuing care for children, adults or families. This service is usually located in communities, making it the first point of contact with the health system for many individuals. This includes essential services such as maternity care, sexual and reproductive health, childhood immunisation, treatment of common childhood illnesses, prevention and treatment of infectious conditions for example TB, HIV and AIDS (WHO, 2012).

In order to ensure that everyone has access to appropriate, efficient and quality health services, South Africa is in the process of introducing an

innovative system of health care financing. The National Health Insurance commonly referred to as NHI will be phased in over a period of 14 years (Republic of South Africa 2011). One of the key interventions that will be addressed by NHI is the provision of a comprehensive package of care underpinned by a re-engineered PHC to focus mainly on health promotion, preventative care and rehabilitative services. The NHI needs a strong district health system (DHS) driving PHC.

PHC is mainly provided by nurses in most countries and this demands more training of PHC nurses (Louwagie, Bachman & Reid 2002: 32). International calls for PHC often refer to the need to educate and train appropriate PHC workers of various types (Hammond & Collins, 1990: 7). To meet the increasing demand of PHC nurses most countries are offering a PHC course. In Queensland, a PHC Reference Unit was established to provide teaching excellence at the graduate and postgraduate level and to contribute to the high quality research in PHC (Rudd 1995: 18). To ensure the availability of PHC nurses, the New Zealand Nursing Council introduced the Nurse Practitioner as a new level of nurse in 2001. The opportunity arose for the introduction of PHC Nurse Practitioner (Maw 2005: 2).

The adoption of PHC approach in 1994 by the South African government placed new demands on the health professions particularly nursing. In 1996, the South African Department of Health formulated a health policy document entitled *Restructuring the National Health System for Universal Primary Health Care*, in which it is stated that a specialized group of registered nurses known as PHC nurses are expected to function independently as frontline providers of clinical PHC services within public health facilities (Department of Health, 1996). This entails, amongst other clinical activities, to examine every

patient that comes to the clinic, treat and discharge those patients that she is able to, or refer them if unable (Department of Health, 2001).

The position of a PHC nurse is regarded as an extended role of the registered nurse and is recognized and regulated by the South African Nursing Council (SANC) through the Nursing Act, No 33 of 2005 (Republic of South Africa 2005). To execute such clinical functions, the Department of Health, emphasizes the need for competency in all health workers in the *Comprehensive Primary Health Care Service Package for South Africa* (Department of Health, 2001), “no member of staff should undertake tasks unless they are competent to do so”. Sibiya & Grainger (2007: 42) state that, nurses provide the bulk of service provision in the public sector, and the need of well-trained primary level staff is imperative. To ensure availability of well-trained PHC nurses the Health Sector Strategic Framework aims to improve Human Resource Planning Development and Management through focusing on training of PHC personnel (Republic of South Africa 2010).

To meet the demand of PHC nurses, most universities in South Africa are also offering a PHC course just like other countries. In Limpopo PHC nurse training was piloted in order to reinforce PHC services and to address the backlog of trained PHC nurses (Dellobelle, Mamogobo, Marincowit, Decock, & Depoorte 2011: 1). According to Van Deventer & Hugo (2005: 57), PHC nurse training had been done for many years in the northern region of the Northern Province.

To ensure the comprehensive training of PHC nurses, a university in Gauteng ‘provides a learning programme as a qualification for a post basic diploma at a

National Qualifications Framework (NQF) level 7: in Clinical Nursing Science, Health Assessments, Treatment and Care. Magobe, Beukes & Muller (2010: 4) state that the course equips registered nurses with clinical knowledge, skills, attitudes and values in patient assessment, diagnosis, treatment and care, incorporating clinical competencies such as the prescribing of schedule 1-4 drugs in the PHC essential drug list (EDL). This university course meets the SANC criteria required for a suitable post-basic learning programme and also has been accepted by the South African Qualifications Authority (SAQA) (Magobe, Beukes & Muller 2010: 4).

The implementation of PHC approach makes the training of PHC nurses essential. Like in other provinces, KwaZulu-Natal (KZN) universities are also offering a PHC course. Regulation R48 (which governs the training of PHC nurses) stipulates that the duration of the course be at least over one year that is 200 days excluding days off. The curriculum includes theory and practice. The minimum requirement of practice hours is 960 (SANC R 48), covered through Work Integrated Learning (WIL). WIL is an educational approach that aligns academic and workplace practices for the mutual benefit of students and workplaces (Council on Higher Education [CHE] 2011: 4). The intention is to encourage students to reflect on their experiences and develop and refine their own conceptual understanding (CHE 2011: 4).

According Groenewald (2004 as cited in Keating 2012: 90), WIL is a process whereby students come to learn through experiences in educational and practice settings and reconcile and integrate the contributions of those experiences to develop the understanding, procedures and dispositions, including criticality and reflexivity, required for effective professional practice. WIL is not a new concept. Most theorists also believed in it for example as

early as 1938 Dewey was one of the educational theorists who strongly believed that people must learn by doing, and that all genuine education is achieved through experience (CHE 2011: 7).

WIL like any other nursing course is essential in PHC as required by the SANC (SANC 1997). In the clinical setting, PHC students develop clinical and diagnostic reasoning; they also learn how to make the appropriate clinical decisions which they need as qualified PHC practitioners. This is achieved through instruction and guidance by lecturers, mentors and clinical staff (Lekhuleni, van der Wal & Ehlers 2004: 15). This instruction and guidance is referred to as clinical accompaniment. However it has been noted that the clinical learning environment confronts students with challenges that are absent from the classroom situation. This exposes students to various experiences (Carlson, Kotze & van Rooyen 2003: 30).

Most South African higher education institutions have found it necessary and useful to prepare students for the world of work, and to help students to gain practical experience through work placement or service learning project (CHE 2011: 6). WIL benefits the student academically thus resulting in increased motivation to learn (CHE 2011: 7) and that creates many opportunities for student learning and the development of critical competencies in the nursing profession (Carlson, Kotze & van Rooyen 2003: 30). To achieve this PHC nursing students are expected to spend 960 hours during their clinical placement as required by the SANC (R48), and this is done through accompaniment as also stipulated in the SANC rules and regulations (SANC, 1997). The SANC is a statutory body entrusted to set and maintain standards of nursing education and practice in South Africa (Republic of South Africa 2005).

The PHC programme aims at producing PHC nurses who are both clinically competent and prepared for clinical practice. Even though WIL has a potential to develop students academically, personally and career-wise, they still need guidance and support by mentors and supervision by staff and lecturers during WIL placement (Lekhuleni, van der Wal & Ehlers 2004: 15). WIL has to take place under supervision of an experienced practitioner. According to Keating (2012: 93), mentorship closely relates to the success of learning and correlates with students being guided towards career development. However, nursing as a practice, like any practice continually faces challenges of development or decline (Benner, 2001: vi).

1.2 PROBLEM STATEMENT

The WIL experiences of undergraduate nursing students in South Africa have been explored by a number of research studies (Mntambo, 2009; Mabuda, Potgieter & Alberts 2008; Waterson, Harms, Qupe, Maritz, Manning, Makobe & Chabeli 2006; Cassimjee & Bhengu 2006; Carlson, Kotze & van Rooyen 2005; Kotze & van Rooyen 2003; Sharif & Masoumi 2005; van Rhyn & Gontsana 2004; Mochaki, 2001; Dhavana-Maselesele, Tjallinks & Norval 2001). Nursing students view clinical placement as the most anxiety producing and stressful component of the nursing programme (Sharif & Masoumi 2005: 2). During WIL placement, students experience anxiety and stress due to lack of support in the clinical environment. They also face various experiences like uncertainty which is due to lack of opportunities to develop competence in providing nursing care (Carlson, Kotze & van Rooyen 2003: 30). These problems do not only affect the undergraduate nursing students but also the post basic students, as they are sometimes regarded as workforce rather than students (Ohaja 2010: 14.3). The researcher did not find any research studies that have explored post basic nursing students' WIL experiences in PHC clinics in KZN. So this study seeks to explore and

describe the WIL experiences of post basic nursing students in PHC clinics so as to address the challenges that are faced within the clinical settings.

PHC is an approach which has the potential to achieve both the Millennium Development Goals (MDG's) and the wider goal of universal access to health care (Walley, et al. 2008: 1003). The vision of the KZN Department of Health is "to achieve the optimal health status for all persons" and the mission is "to develop and deliver a sustainable, co-ordinated, integrated and comprehensive health system at all levels of care based on the PHC approach" (KZN Department of Health, 2010). With the implementation of NHI, PHC services will be re-engineered to focus mainly on community outreach services that will ensure health promotion, preventive care as well as quality curative and rehabilitative services.

Three streams approach to PHC re-engineering adopted by Department of Health are:

1. Ward-based PHC outreach team for each electoral ward
2. Strengthening school health services
3. District-based clinical specialist team with an initial focus on improving maternal and child health (Department of Health 2011).

Each ward will have a PHC outreach team that will be led by a PHC nurse. This implies new challenges for a PHC nurse who will have to manage PHC service delivery according to the new NHI specifications. Thus if challenges that are related to clinical training of PHC nurses are addressed this would ultimately improve the efficiency of health service delivery in PHC clinics.

1.3 PROFILE OF THE RESEARCHER

I was a student registered in Clinical Nursing Science, Health Assessment, Treatment and Care (R48) in 2008-2009 at the university under study. I had experience with clinical placement as I was also placed for clinical placement in two years of my practice as a PHC student. In 2008 I was placed in a Gateway Clinic and in 2009 in a Community Health Centre (CHC) as a result, I had different clinical experiences and challenges. In 2009, I had to adjust to a new environment that was different from the one that I was already used to, the previous year. The latter clinical facility was bigger and comprehensive than the former one.

This research stems from my interest in exploring the experiences of nursing PHC students regarding WIL placements as I encountered a number of challenges in the clinical area during the time of placement for clinical exposure. Anecdotal evidence from my experience as a nursing PHC student is that in order for students to master the clinical skills, he or she must get clinical supervision, support and guidance from the university lecturers and trained nurses.

1.4 AIM OF THE STUDY

The aim of this study was to explore and describe PHC post basic nursing students' experiences during clinical placements.

1.5 RESEARCH QUESTION

The main research question for this study was:

- 'What are the experiences of primary health care post basic nursing students regarding WIL?

In order to probe the participants for further discussion, the following questions were used as a guide:

- How do you ensure that your WIL expectations are met in the clinical setting?
- What are the challenges that you are faced with in the clinical setting?
- What would you like to see being improved in the clinical setting?
- Further questions were based on the participants' responses

1.6 THEORETICAL FOUNDATIONS OF THE STUDY

A conceptual framework for WIL as adapted from CHE (2011: 8-9) was used to guide the study. A profession is made up of three different fields. The first field is the academic that provides the scientific basis for the profession. The second field is the educational and entails the selection of professional concepts by the academic staff as well as the methods of teaching and assessment that are appropriate to students' professional development. The third field involves the transformation of the knowledge learning at the university in their field of practice. Building clear linkages between the three fields benefit student learning. The WIL approach attempts to build linkages between the world of teaching and learning, and the world of professional practice. Further discussion on the theoretical framework will be presented in Chapter 3.

1.7 SIGNIFICANCE OF THE STUDY

The position of a PHC nurse is regarded as an extended role of the registered nurse and is recognized and regulated by the South African Nursing Council (SANC) through the Nursing Act, No 33 of 2005. To execute such clinical functions, the Department of Health, emphasizes the need for competency in all health workers in the *Comprehensive Primary Health Care Service Package for South Africa* (Department of Health, 2001), “no member of staff should undertake tasks unless they are competent to do so. To ensure availability of well- trained PHC nurses the Health Sector Strategic Framework aims to improve Human Resource Planning Development and Management through focusing on training of PHC personnel (National Department of Health 2010).

In South Africa the training of PHC nurses is regulated by the South African Nursing Council. The curriculum of PHC training includes theory and practice. The minimum requirement of practice is 960 hours (SANC R48), which is covered through WIL. During WIL students are placed in the clinical field and it is an essential and irreplaceable resource that helps in preparing a student for his or her professional role (Midgley 2005: 339), as he or she is the future provider of competent and safe nursing care (Carlson, Kotze & van Rooyen 2003: 30). The clinical environment encompasses all that surrounds the nursing students, which includes the clinical setting, the equipment, the staff, the patients, the nurse mentor and the nurse educator (Papp, Markkanen & von Borsdorff 2005: 1).

Papp, Markkanen & von Borsdorff (2005: 2) describe the clinical setting as an important element in the whole learning process of student nurses. To grow and to develop professionally the student nurse needs to be provided with an

appropriate learning environment, relevant resources and desirable level of structured support and guidance however students have expectations as to how and what the clinical field can and should provide although undoubtedly these expectations differ (Midgley 2005: 343). Clinical practice provides student with an opportunity to correlate theory into practice but it has been noted that during WIL there are factors that enhance or hinders students' clinical practice (Chapman & Orb, 2000: 7).

This study therefore seeks to explore and describe the WIL experiences of post basic nursing students in PHC clinics so as to address the challenges that students' experience in the clinical settings. It seeks to gain a broader understanding of students' experiences at different levels of their training that is first and second year of study.

The findings of this study will provide nurse educators with a meaningful understanding of the experiences of clinical practice as perceived by post-basic nursing students. Nurse educators can use the knowledge on experiences by post basic PHC nursing students in clinical placement to plan learning opportunities in such a way that learning and practice of nursing skills are less stressful to students. This can also help nurse educators to develop an effective clinical teaching strategy in nursing education. Challenges that are related to clinical training of PHC nurses will be addressed, and this would successfully lead to a more skilled and competent workforce which in turn will improve clinical outcomes such as; reducing clinical risk, providing more effective intervention and increasing quality of care for clients.

1.8 CONCLUSION

This chapter presented a background of PHC, the training of PHC nurses and the experiences of undergraduate nursing students during WIL. So this study seeks to explore and describe the WIL experiences of post basic nursing students in PHC clinics so as to address the challenges that nursing students are faced with in the clinical settings. Chapter 2 will present the literature on WIL.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter presented a background of PHC, the training of PHC nurses and the experiences of undergraduate nursing students during WIL. This chapter will present literature review that highlights PHC and WIL experiences of nursing students in the clinical facilities in different countries. A nexus search of the literature was conducted over a period of six months, using different scholarly search engines. The search strategy included using obvious key words related to WIL, clinical instruction combined with experiences of nursing students in the clinical facilities or related terms, as well as nurses or related terms. The World Wide Web including search engines such as Google Scholar was also searched for similar key words, producing a number of further papers and resources. The reference lists of key articles were scrutinized and this identified other relevant articles. In order to provide a complete an overview of available knowledge and resources, peer reviewed and non-peer reviewed journals; materials on the World Wide Web were used. Titles, in case of doubt, abstracts were assessed on suitability for inclusion in the literature review.

2.2 GLOBALISATION TRENDS

PHC has been globally accepted as an appropriate strategy for universal coverage of essential health care (Dennil, King & Swanepoel 1999: 29), on equitable basis, accessible at an affordable cost. According to Schaay & Sanders (2008: 11), Thailand began implementing PHC in 1977 and the programme has now expanded to include the HIV and AIDs and a focus on achieving the MDGs. In accordance with the Alma Ata Declaration, Saudi

Arabia identified the development of PHC as one of its most important strategies and PHC is a pioneering program that has achieved considerable success within a few years of its establishment (Al-Ahmadi & Roland, 2005: 331). This success is reflected in good access and effectiveness of some traditional primary care services such as immunisation, maternal health and control of endemic diseases. According to Atun, Kyratsis, Jelic, Rados-Malicbegovic & Gurol-Urganci (2007: 28) most transition countries in Central, Eastern Europe and Central Asia are engaged in health reform initiatives aimed at introducing primary health care centred on family medicine to enhance performance of their health system. As stated by Toni (2009:1) The New Zealand Health Strategy (2000) identified PHC as one of five service priorities for improving the health of New Zealanders.

In most countries, PHC is mainly provided by nurses (Louwagie, Bachman & Reid 2002: 32), and that demands more training of PHC nurses. The training of nurses is regulated by the statutory body and as part of the requirement nurses are expected to spend a stipulated number of hours in clinical practice and this is achieved through WIL.

In Australia, the practice of nursing was previously governed by state and territorial nursing regulation authorities and in 1992, the Australian Nursing and Midwifery Council (ANMC) was established. As of 1 July 2010, the nurses were regulated by the Nursing and Midwifery Board of Australia (NMBA), an agency under the Australian Health Practitioner Regulation Agency (AHPRA) under the National Registration and Accreditation Scheme. To ensure the high standard in the profession the NMBA accredits nursing programs in the universities, approves programs by other educational providers and sets the standards and guidelines for nursing practice.

Although WIL is regarded as an essential part of the nursing education, research has demonstrated that students experience problems and difficulties during their clinical placement. In Western Australia for instance, students experienced anxiety due to theory-practice gap that is conflict between what is taught in the classroom and what happens in the real world (Chapman & Orb, 2000: 2). To meet the increasing demand of PHC nurses, most countries are offering a PHC course.

In New Zealand the Graduate certificate in Primary Health Care aims to provide students with the knowledge and skills to incorporate the principles of primary health care in order to reduce inequalities in health care access. The course is offered in one of the Universities for the period of one year. Like in other countries, the training of nurses is regulated by the statutory body that is The Nursing Council of New Zealand (NCNZ). The Council is responsible for the registration of nurses and its primary function is to protect the health and safety of members of the public by ensuring that nurses are competent and fit to practise. To ensure competency in 2000 the Nursing Council of New Zealand conducted a strategic review of nursing education which acknowledged the challenge of managing the clinical learning components of nursing education and recommended establishing programmes to prepare and to support the student during WIL (Gabb & Keating 2005: 6).

During WIL nursing students are expected to spend a stipulated number of hours as a requirement by the statutory body. Nursing education in Finland is a 3.5 year programme consisting of 210 credits. This includes 90 credits of clinical practice meeting the criteria laid down by the European Union Council Directives for nursing education (Matilla, Pitkajarvi & Ericksson 2009: 153). The average length of clinical practice period is five weeks and it is carried in

accredited clinics and hospitals. However it has been noted that during clinical practice students experienced challenges such as being ignored by the nursing staff as no one showed interest in their learning (Matilla, Pitkajarvi & Eriksson 2009: 155).

In the United Kingdom the Nursing and Midwifery Council (NMC) currently maintains a register of qualified nurses, sets standards for education, practice and professional conduct and deals with allegations of misconduct or unfitness to practice (Gabb & Keating 2005: 4). Even though the clinical field is an essential and irreplaceable resource in preparing the student nurse for the professional role (Midgley 2005: 339), Campbet et al. cited in Midgley (2005: 343) state that the literature identifies that for various reasons many nursing students perceive the clinical area as laden with anxiety and stress and often vulnerable.

Eraut (1994 cited in Orrell 2004: 1) states that internationally higher education is called to account for success in the employment of its graduate. To achieve success, nurse educators should collaborate with employers to offer creative clinical experience for students and maximise readiness for the work world (Gabb & Keating 2005: 5). This collaboration was also recommended by Canadian Nursing Advisory Council (CNAC) in a wide range review of nursing that was conducted in 2002. Good co-operation between the school and the clinical staff has proven to be effective, in the study that was conducted by Papp, Markkanen & von Bonsdorff (2002: 4) the results showed that a good clinical learning environment was established through good co-operation between the school and the clinical staff, the best learning experiences originated in situation that were planned well in advance and carried out without any haste and this facilitated patient-oriented care.

2.3 PRIMARY HEALTH CARE IN SUB-SAHARAN AFRICA

In Nigeria the formal apprenticeship training of nurses started as early as 1930 (Adebanjo & Olubiyi 2008: 1). In 1946 the post basic training in specialty areas such as Midwifery, Ophthalmic and Psychiatry to mention a few was started (Adebanjo & Olubiyi 2008: 2). To add on the specialization courses, the National PHC was launched by the Military administration of President Babangida in 1988, and he stated that it should be people oriented in that it strives to develop local capabilities, initiatives and to promote self-reliance (Adeyemo 2007: 152). The training of nurses in Nigeria is also regulated by the statutory body like in any other country. Nursing and Midwifery Council (NMC) regulates all the schools of nursing in Sub Saharan Africa (NMC, 1979). As part of the requirement students are expected to spend a stipulated number of hours in the clinical practice. However it has been noted that the clinical learning environment confronts students with challenges that are absent from the classroom situation. This exposes students to various experiences (Carlson, Kotze & van Rooyen 2003: 30).

In Swaziland nursing education is regulated by the Swaziland Nursing Council (SNC). The SNC is an Autonomous Statutory body established by the Nurses & Midwives Act, No. 16 of 1965. It is responsible for regulating, directing and controlling the Nursing Practice and Nursing Education in the country. Nursing education in Swaziland has also experienced the transition from the hospital-based model to higher education in the late nineties (Mthembu & Mtshali 2012: 3). In Swaziland clinical nursing education was also found to be an essential component in the nursing curriculum, but the study that was conducted by Mthembu & Mtshali (2012: 2) revealed that there were barriers to the integration of theory and practice.

2.4 TRAINING OF PHC NURSES IN SOUTH AFRICA

The nursing and midwifery professions in South Africa are regulated mainly by the SANC which is a professional body, entrusted to set and maintain standards of nursing education and practice (Republic of South Africa 2005). Other important authorities include the National Qualification Framework (NQF), and the South African Qualification Authority (SAQA) who have to register all higher education qualifications (Wessels 2001 cited in Moleki 2005: 12). SANC (Regulation, 48) stipulates that the duration of the course shall extend over at least one academic year of at least two hundred days (excluding days off), and students shall throughout the course receive instruction both theoretically and clinically, and undergo practica in the subjects prescribed (SANC, 1997). According to SANC (Regulation 48), the minimum requirement of practica for PHC is 960 hours. This can be achieved through a component of a learning programme that focuses on application of theory in an authentic work-based context, namely WIL (Republic of South Africa, 2004). However it has been noted that during WIL nursing students experience challenges. For instance the study conducted in South Africa by Carlson, Kotze & van Rooyen (2003: 30) revealed that students experienced uncertainty due to lack of accompaniment as senior professional nurses were not aware of their needs and problems in clinical placement. These experiences do not only affect students allocated in general wards, but also students in speciality areas. The study that was done by Ohaja (2010: 14) in the Northern Province, psychiatric units showed that students were stressed due to ineffective teaching and learning programme. Moreover students felt neglected by clinical staff as registered nurses were not engaged in clinical accompaniment due to shortage of staff (Mochaki 2001: 15).

The above does not only affect the undergraduate students but also the post basic students, as midwifery basic students experienced role conflict during

their placement due to the fact that they were regarded as the workforce rather than students (Ohaja, 2010: 14.3). PHC post basic students also experienced the similar problem which contributed to their poor clinical competency at the end of their training (Magobe, Beukes & Muller 2010). However students do not always face negative experiences. They sometimes face positive experiences as they are supported by skilled nursing staff, doctors and junior nurses (Mntambo 2009: 147). This is also evidenced by Williamson, Callaghan, Wittlesea, & Heath (2010: 8) whose study revealed that students were satisfied with their clinical placements as they were supported through mentoring and accompaniment.

2.5 ENHANCING LEARNING IN THE CLINICAL ENVIRONMENT

To enhance learning of nursing students, different clinical teaching approaches are used, namely clinical accompaniment, preceptorship and mentoring.

2.5.1 Clinical accompaniment

Clinical accompaniment means a structured process by a Nursing Education Institution (NEI) to facilitate assistance and support to the student nurse education in a clinical facility to ensure the achievement of the programme outcome (Republic of South Africa 2011), this result to the student growth to the level of independent practice (SANC Terminology List 1994: 2). Willison & Kingston (2009 cited in Mntambo 2009: 27) define accompaniment as a process in which student nurses are supported by a mentor during clinical practice in a clinical environment.

Nurse educators are required by the statutory body to ensure that students are accompanied during clinical placement and that is done by a relevant person that is someone who is knowledgeable and professionally matured, an expert in the field of nursing with an in- depth knowledge of the practice of nursing and with relevant nursing experience (Masango-Mtetwa 1999: 34). Bourbonnais & Higuchi (1995 cited in Masango- Mtetwa 1999: 34) state that the nurse educator must also possess pedagogical content knowledge and be able to apply this knowledge to the unique demands of the clinical learning environment. SANC (2011: 7) requires the NEI to submit the name(s) and professional qualifications of the person(s) responsible for the structured clinical guidance and the clinical accompaniment, as well as the number of students/pupils each preceptor is responsible for annually, for as long as the clinical facility is to be used by the NEI. To ensure that clinical accompaniment is done regularly or as required, a documented evidence of clinical accompaniment must be kept (SANC 2011: 7).

2.5.2 Preceptorship

Preceptorship is a method of preparation for practice, utilising clinical staff as opposed to faculty staff, to provide supervision and clinical instruction to new practitioners, undergraduates newly registered or new to a specific clinical environment (Mills, Francis & Bonner 2005: 5). It is believed to be the perfect medium to bridge theory and practice. In Canadian undergraduate programmes, preceptorship is typically described as a formal one to one relationship between a nursing student and a registered nurse that extends over a pre-determined length of time (Sedgwick & Harris 2012: 1). As preceptorship is wide used many nurse scholars believe that it provides the perfect medium to bridge theory and practice (Sedgwick & Harris 2012: 1). In Botswana preceptorship was adopted to improve clinical nursing education

(Monareng, Jooste & Dube (2009: 113). Preceptorship is also used in post graduate programmes, in one of the universities in the Limpopo clinical reasoning of PHC post basic nursing students was improved through on-site supervision by individual preceptors (Delobelle et al 2011: 292).

The findings of the study that explored the partnership between preceptors and preceptees revealed that all parties saw the preceptorship partnership as positive and a learning experience (Turner, 2007: 4). Although preceptorship is done by the professional nurse in a clinical environment, nursing students' development is not solely the responsibility of a unit professional nurse it is also the responsibility of a NEI (SANC, 2011: 7). The major role of a preceptor is to show appropriate nursing behaviours and act as a role model for the students. Preceptorship has a lot of advantages for the student, preceptor herself and the institution. According to Mantzorou (2004: 4) preceptorship offers a student professional nurturance which contributes to the student development of socialization and professional roles. According to Bizek & Oermann (1993 cited in Mantzorou, 2004: 4) the preceptor role constitutes a professional challenge and offers stimulation and motivation thus helping preceptors to develop their skills in mentoring students as well as improving their professional and leadership roles. Ellis (1993 cited in Mantzorou 2004: 4) argue that preceptorship assists in personal development and staff appraisal, encourage a learning climate and lead to higher standards of care. Preceptorship also helps the faculty to capture the strengths and weaknesses of students in the clinical practice.

Sedgwick & Harris (2012: 3) highlight that although leaders in clinical setting acknowledge the importance of clinical education, clinical placements

including preceptorship are not without problems. Preceptors sometimes find it difficult to cope with the demands of their own position which may cause potential drawbacks (Mantzorou, 2004: 5). Other potential drawbacks could be semester breaks of students as well as absence of preceptors which do not allow students to have consistent resource person and role model Chickerella & Lutz (1981 cited in Mantzorou 2004: 5). Rittman (1992 cited in Mantzorou 2004: 8) concludes that preceptorship has always been a vital part of the practice of nursing providing backup, support and learning to both patients and colleagues.

2.5.3 Mentorship

According to Mills, Francis & Bonner (2005: 3), mentoring in nursing is a teaching-learning process acquired through personal experience within a one to one reciprocal career development relationship between two individuals diverse in age, personality, life cycle, professional status or credentials. A mentor is a designated person who dedicates some of his or her time to help individuals to learn during the developmental years to progress towards and achieve maturity and establish identity. Effective mentorship is critical in delivering high quality care, ensuring patient safety and facilitating positive development of staff (Frankel 2008: 1). Proactive mentorship can thus be seen as a balance between exposing students to challenging experiences based on their individual learning styles, whilst also providing purposeful support (Cassidy 2008: 35). In mentoring a senior person mentors a junior person. According to Grossman (2007 cited in Mntambo 2009: 66) mentoring can be reverse that is where a junior person mentors a senior person. Mentoring can also be done in different methods; one of other methods of mentoring is peer mentorship. Grossman (2007 cited in Mntambo 2009: 66) describes this type of interaction as the one that occurs between people of

equal knowledge, experience and seniority. Mentoring requires a very similar high level of commitment from each participant for the relationship to be established (Mills, Francis & Bonner 2005: 6). In order to meet the high level of commitment, a university under study expects a mentor and the student to sign a mentoring agreement that is retained in the student's practical workbook for the entire period of study (See Appendix 8). Mentoring has a great influence on students. The study that was conducted by Papp, Markkanen & Bonsdorff (2002: 4) revealed that mentors set a good professional model for the future nurse. Steward & Kruger (1996: 318) view mentoring in nursing as a teaching-learning process for the socialization of nurse scholars and the proliferation of a body of professional knowledge.

2.6 CONSTRUCTIVIST MODEL TO ENHANCE CLINICAL LEARNING

Nursing practice is the heartbeat of the profession and nursing theory is the rhythm of the heartbeat (Robert & Pape 2011: 41). There is a need for integration of both environments. Figure 3.2 below demonstrates how clinical learning could be enhanced using the Constructivist Model.

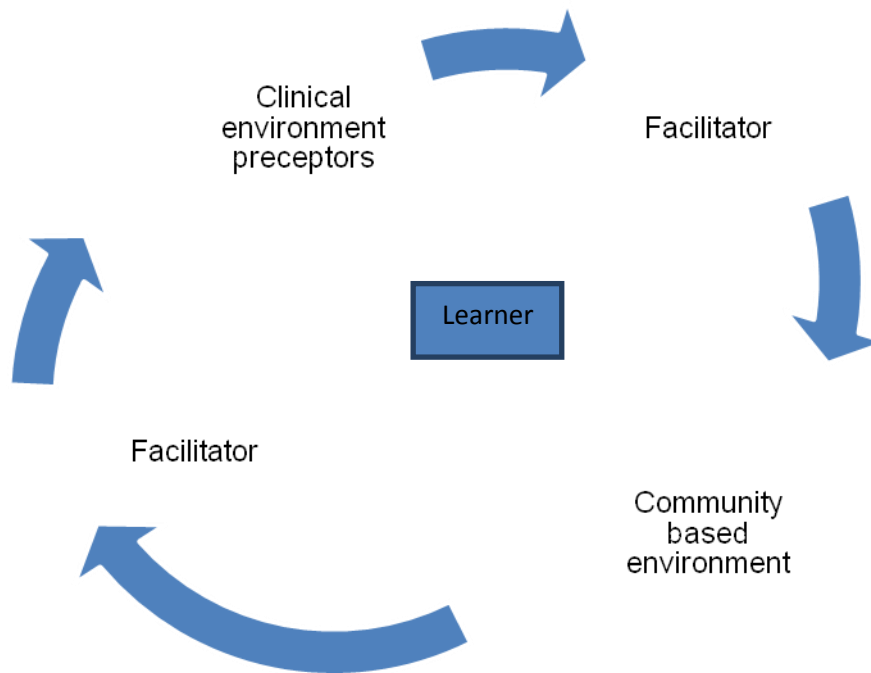


Figure 2.1: Constructivist model to enhance clinical learning (Robert & Pape 2011).

Schunk (2004 cited in Kuiper, Heinrich, Matthias, Graham & Bell-Kowall 2008: 2) explains constructivism as a philosophy that states individuals form or construct what they learn and understand. A spiral has a centre point that encompasses the learner. Within the centre, learners interact. This constitutes a group that interacts with the facilitator. The facilitator becomes the mediator. This brings learner closer to the context. The facilitator creates meaningful zones of proximal development and cognitive bridges through social interaction. Evaluation is constant throughout the process. Students use previous knowledge to develop more complex ideas and integrate information.

2.6.1 Assumptions of the model

Previous constructs are the foundation of the learning process in each learner. Learners know the world through the existing mental frameworks. Baker, McGaw & Peterson (2007: 3) argues that knowledge is actively constructed by the learner. These authors further argue that learners come to learning situation with existing ideas about many phenomena. New information is transformed and interpreted based on previous learning. Assimilation and accommodation processes lead to new constructions. Learning is an organic process of invention, not mechanical. Learners develop the ability to hypothesize, predict, manipulate and construct knowledge as more meaningful teaching than memorization of facts. Meaningful learning occurs through reflection and by linking new knowledge to an existing framework of knowledge. Enhancing clinical teaching ensures integration of theory to practice. It is a collaborative effort between the nursing education institutions and the clinical environment. The nursing education institutions develop scientific process and the role of the clinical environment is to provide a supportive platform.

2.7A PROPOSED MODEL FOR CLINICAL NURSING EDUCATION AND TRAINING IN SOUTH AFRICA

The Nursing Education Stakeholders, consisting of representatives from College Principals and Academic Staff (CPAS), Democratic Nursing Association of South Africa (DENOSA), (Forum of University Nursing Deans in South Africa (FUNDISA), Nursing Education Association (NEA), Nurse Managers, Private Health Education Providers of South Africa (PHEPSA) and SANC at their meeting in September 2010 identified the clinical education and training of nurses in pre-registration programmes as an important area of concern in improving the quality of nursing education (Fundisa, 2012).

Stakeholders had a meeting in October in Pretoria to develop a discussion document for wider consultation. A proposed model for clinical nursing education and training was developed. See Figure 2.1. The major precepts of the model suggested by the group to optimise learning in clinical settings and produce competent nurses and midwives are:

- That clinical practica for learning (experiential learning) in which students can work with patients without forming part of any service team are distinguished from clinical practica for role-taking (work-based learning), during which students do form part of the service team
- A system of clinical preceptors is implemented to ensure minimum level of clinical teaching and support for students during their clinical practice
- The Clinical Placement Co-ordinator manages the clinical teaching system and ensures its functionality and quality
- Teaching and support of students in clinical settings to form part of the job description of the clinical supervisors
- Students are only placed in clinical facilities where a certain level of quality of nursing care based on clearly defined standards is given. Therefore, a Positive Practice Environment (PPE) must be ensured
- Nurse educators are expected to remain clinically competent in their field and be part of the clinical preceptor team
- Clinical Teaching Associates (CTAs), who are experts in practice be recognised and involved in classroom teaching in order to provide clinical role models for students (Fundisa, 2012).

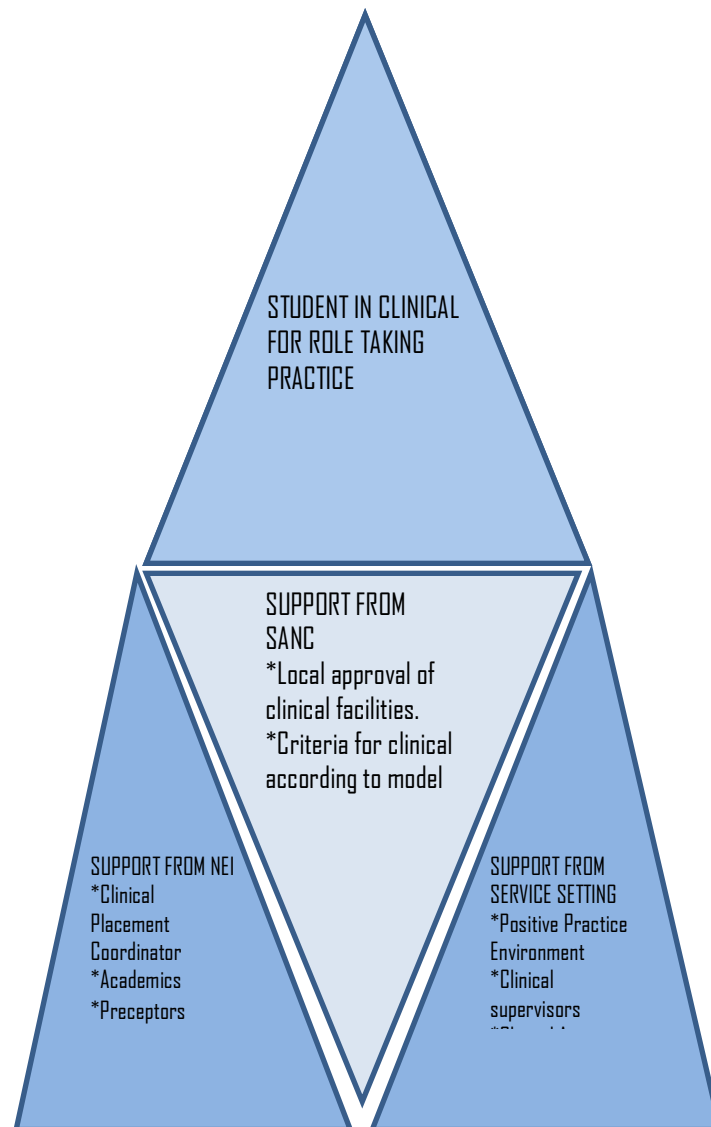


Figure 2.2: A proposed model for clinical nursing education and training

2.8 CONCLUSION

Nursing students must be guided to a stage where they can assume responsibility for their nursing actions (Van Rhyn & Gontsana 2004: 25). This guidance is through WIL. This chapter presented literature review on WIL. Although literature highlights that WIL is a requirement by the statutory body, it creates many opportunities for student learning and development of critical

competencies in the nursing profession. While it is regarded as an essential part of the nursing education, research has demonstrated that students experience problems and difficulties during their clinical placement. Chapter 3 will present research methodology.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter presented literature review on WIL. This chapter will address methods used in the research design, research setting, sampling process, data collection, data analysis and ethical consideration.

3.2 RESEARCH DESIGN

A descriptive exploratory qualitative study was used. According to Kumar (2005: 10) a descriptive exploratory approach attempts to describe systematically a situation, problem, phenomenon, programme or attitudes towards an issue and to explore an area where little is known. The purpose of the descriptive design is to provide a picture of a situation as it naturally happens (Burns & Grove 2007: 264). The researcher chose the descriptive exploratory qualitative design for this research as it allowed an opportunity to explore the experiences of the participants studied. It also gave the participants an opportunity to share a holistic view of the events, which would allow a comprehensive summary of the knowledge gathered written up in everyday terms. The design enabled exploration and description of the experiences of PHC nursing students on WIL.

3.3 STUDY SETTING

Descriptive qualitative studies are often conducted in natural setting (Burns & Grove, 2007: 352). Data was collected from PHC post basic nursing students who were allocated for WIL at the clinics in Health District A and Health District B in KZN, South Africa in 2011. Health District A and B comprise of

hospitals, CHCs and PHC clinics. Districts A was selected, because of its proximity to the university that was studied; so the majority of the students came from this district. District B was selected as the majority of the students that reside in the midlands areas were allocated in accredited PHC sites that are in this district.

According to the KZN Health Strategic Plan 2010-2014, KZN is the second most populous province in South Africa with a total population of 10 449 300 (KZN Department of Health, 2010: 11). To illustrate the need for additional number of efficient and competent PHC nurses, the Strategic Plan further documents that the PHC headcount increased with 21% between 2005/2006 and 2008/2009 with 23 838 854 clients visiting PHC services in 2008/2009. Fixed PHC clinics increased from 450 in 2005 to 577 in 2008/2009 and CHCs increased from 14 to 16 during the same period.

3.4 BACKGROUND OF SELECTED HEALTH DISTRICT

3.4.1 Health district A

Health district A is in a metropolitan area. According to the District Health Plan 2007-2008, the total area of this district is only 1, 4% of the total area of the province and it contains over a third of the population of KZN and 60% of its economy activity (KZN Department of Health, 2006). This district has a population of 3 388 835, which is 33, 9% of the total population of the Province. Only 35% of the municipal area is predominantly urban and the remainder is rural to semi-rural. PHC services in this district are jointly provided by the Provincial Department of Health and the Local Government Authority, with the former contributing 60% and the latter 40%. Provincial facilities within the District A are distributed as follows: eight CHCs and 47

PHC clinics. On the other hand the Municipality has 77 PHC clinics and 15 mobile units, with one CHC shared by both authorities. The catchment population ratio per clinic is 1: 22 570 which is above the national norm of 1: 15 000.

3.4.2 Health district B

Health district B is located in the Midlands of the KZN Province. The district consists of seven local municipalities (KZN Department of Health, 2006: 8). According to the District Health Plan 2007-2008, health district B has a population of 996 342 (KZN Department of Health, 2006: 8). The district has 48 fixed clinics, 17 mobile clinics, four CHCs and nine hospitals. Out of 48 fixed clinics, 22 are provincial clinics, 17 local government clinics, eight satellite clinics and two state aided clinics. 75% of the identified clinics are open 24 hours a day and 53% offer services extended hours (KZN Department of Health, 2006: 21).

3.5 STUDY POPULATION

According to Polit & Beck (2010: 273) population is the entire aggregation of cases in which a researcher is interested. In this study the population was comprised of students who were registered for post basic course in Clinical Nursing Science, Health Assessment, Treatment and Care in 2011 in the university that was studied. In this study the target population that is aggregate of cases about which the researcher would like to generalise (Polit & Beck 2012: 274) consisted of students that were in their first year of study (PHCI) and students that that were in their second year of study (PHCII). The course was offered on part time basis over a period of 2 years. The students attended classes once a week and they did their practical one day per week from April 2011 until the end of the year.

Polit & Beck (2012: 274) describes the accessible population as the aggregate of cases that conform to designated criteria and are accessible for a study. In this study the accessible population was all PHCI and PHCII students that were allocated in Health District A and Health District B for their clinical practice. These students were allocated in Community Health Centres (CHCs) and PHC clinics.

3.6 SAMPLING PROCESS

Sampling is a process of selecting cases to represent the entire population so that inferences about the population can be made (Polit & Beck 2012: 275). In this study a purposive sampling was done. According to Kumar (2005: 179) the primary consideration in purposive sampling is the judgement of the researcher as to who can provide the best information to achieve the objectives of the study. All consenting students registered Clinical Nursing Science, Health Assessment, Treatment and Care in the university that was studied and that were placed in the clinical settings in Health District A and B took part in the study. The enrolment for PHC students in 2011 was 52. There were 35 students who were registered for first year and 17 students who were registered for the second year.

The ultimate goal of purposive sampling is to select information-rich cases from which a researcher can obtain in-depth information needed for the study Morse (2007 cited in Burns & Groves 2007: 313). To obtain in-depth information data was collected at the end of first year and second year of study to ensure validity as the student would have adequate exposure at the clinical settings.

3.6.1 Sample Size

The number of participants in a qualitative study is adequate only when saturation of information is achieved in the study area (Burns & Groves 2007: 348). Data saturation is when themes and categories in the data become repetitive and redundant, such that no new information can be gleaned by further data collection (Polit & Beck 2010: 62). When additional sampling provides no new information, only redundancy of the previous information the researcher will know that data saturation has been achieved. In this study data collection continued until data saturation was reached after interviewing ten participants.

The sample consisted of both levels of study namely first year PHCI and second year students PHCII. The first year students were 35 and second year students were 17. Students were expected to spend 960 hours in PHC clinical placements as required by the SANC (R48), of which 388 hours are covered in first year where a paediatric module is done and the outstanding 572 hours are done in second year of study on adult health assessment. Students were placed in different PHC clinics that are approved by SANC. Table 3.1 below shows the list of participants and the list of districts in which they were allocated to.

Kumar (2005:165) describes the sample size as the number of students, families or electors from whom the researcher obtains the required information. In this study the actual size of participants was ten, six participants were placed for clinical placement in District A and four participants were placed for clinical placement in District B. Out of the six participants that were allocated for clinical placement in District A four were in the end of their second year of study and two participants were in the end of their first year of study. In District B, two participants were in the end of their

second year of study and the other two participants were in the end of their first year of study.

Table 3.1: List of Participants and Districts

Participants	District
Participant 1 2 nd year	Health District A
Participant 2 2 nd year	Health District B
Participant 3 2 nd year	Health District A
Participant 4 2 nd year	Health District A
Participant 5 2 nd year	Health District B
Participant 6 2 nd year	Health District A
Participant 7 1 st year	Health District B
Participant 8 1 st year	Health District A
Participant 9 1 st year	Health District B
Participant 10 1 st year	Health District A

3.7 DATA COLLECTION

Polit & Beck 2012:52 define research data as the piece of information obtained in a study. Data collection is the process of acquiring the subjects and collecting the information for the study (Burns & Groves 2007: 52). Data can be primary or secondary. Kumar (2005: 118) refers to the obtained or collected data as the primary data as it is the first hand information and already available data as the secondary data. The most commonly used data collection strategy in qualitative research is an interview. Burns & Groves 2007: 350) define an interview as a verbal communication between the researcher and the subject during which information is provided to the researcher. An interview can be unstructured or structured.

In-depth interview is one of the classifications of an interview. Kumar (2005: 124) defines in-depth interviewing as repeated face to face encounters between the researcher and informants directed towards understanding informants perspectives on their lives, experiences, or situations as expressed in their own words. In this study, in-depth interviews were conducted with PHC post basic nursing students with an aim of exploring their experiences on WIL.

One broad question was asked: 'What are your experiences with regard to work integrated learning (WIL) at the clinics?' In order to probe the participants for further discussion, the following questions were used as a guide:

- How do you ensure that your WIL expectations are met in the clinical setting?
- What are the challenges that you are faced with in the clinical setting?
- What would you like to see being improved in the clinical setting?
- Further questions were based on the participants' responses.

The participants were free to express their views regarding their WIL experiences. The use of an interview guide enabled the researcher to focus on the necessary issues but did not require the questions to be asked in the same sequence for each of the interviews but rather would be dependent on how each question was answered. Participants' permission was obtained to audio-tape interviews. Each interview session was 45 minutes. Interviews were conducted in a clinic after lunch when it was not too busy, or at the participant's home or at the university. Interviews at the university were conducted in the afternoon in order to avoid disruption of classes. Interviews were conducted in a quiet room to avoid disturbances. The participant was

asked to put aside the required amount of time so as to give undivided attention (Terre Blanche, Durrheim & Painter 1999: 5). Questions and thoughts that occurred while the interviewee was speaking were written by the researcher so as not to interrupt the contact and flow of an interview.

3.8 CONCEPTUAL FRAMEWORK THAT GUIDED THIS STUDY

This study was guided by a conceptual framework for WIL as adapted from CHE (2011) See Figure 1. According to this framework, a profession is made up of three different fields. The first field, the academic field provides the scientific basis for the profession. The second field, the educational field entails the selection of professional concepts by the academic staff as well as the methods of teaching and assessment that are appropriate to students' professional development. The third field involves the transformation of the knowledge learning at the university in their field of practice. Building clear linkages between the three fields benefit student learning. The WIL approach attempts to build linkages between the world of teaching and learning, and the world of professional practice.

Figure 3.1 shows how the three worlds can be brought into alignment. WIL cannot occur without partners who represent the different knowledge fields. The effectiveness of WIL depends to a major extent on the commitment of both academic and professional partners.

3.8.1 Elements of a conceptual framework

3.8.1.1 Academic field

According to CHE (2011: 9) the academic staff, in their roles as researchers, develop new knowledge and thinking in their field of specialisation.

3.8.1.2 Educational field

University teachers select topics and concepts for their students to study, and devise methods of teaching and assessment that are appropriate for the students' conceptual development. (CHE 2011: 9).

3.8.1.3 Professional practice

As stated CHE (2011: 9) professionals transform the knowledge learned at university in their field of practice.

3.8.2 Justification for using a conceptual framework for WIL

A profession is made up of three different fields that is the academic field that provides the scientific basis for the profession, the educational field which includes the curriculum, various teaching and learning strategies and assessments and the professional field which is considered during the development of the educational programme. Building clear linkages between the three fields benefit student learning. It is beneficial for the student to engage with the world of science, with an experienced lecturer as a guide; and it is also beneficial for a student to engage with the world of professional practice. The WIL approach attempts to build linkages between the world of teaching and learning, and the world of professional practice. Figure 1 shows how the three worlds can be brought into alignment; the dotted line suggests that there is not a rigid separation between the academic and professional

elements of WIL (in the sense elements of professional practice can be drawn on in constructing a curriculum for academic subjects. The focus of WIL is however, professionally-oriented education, as shown by the highlighted areas in Figure 3.1 below.

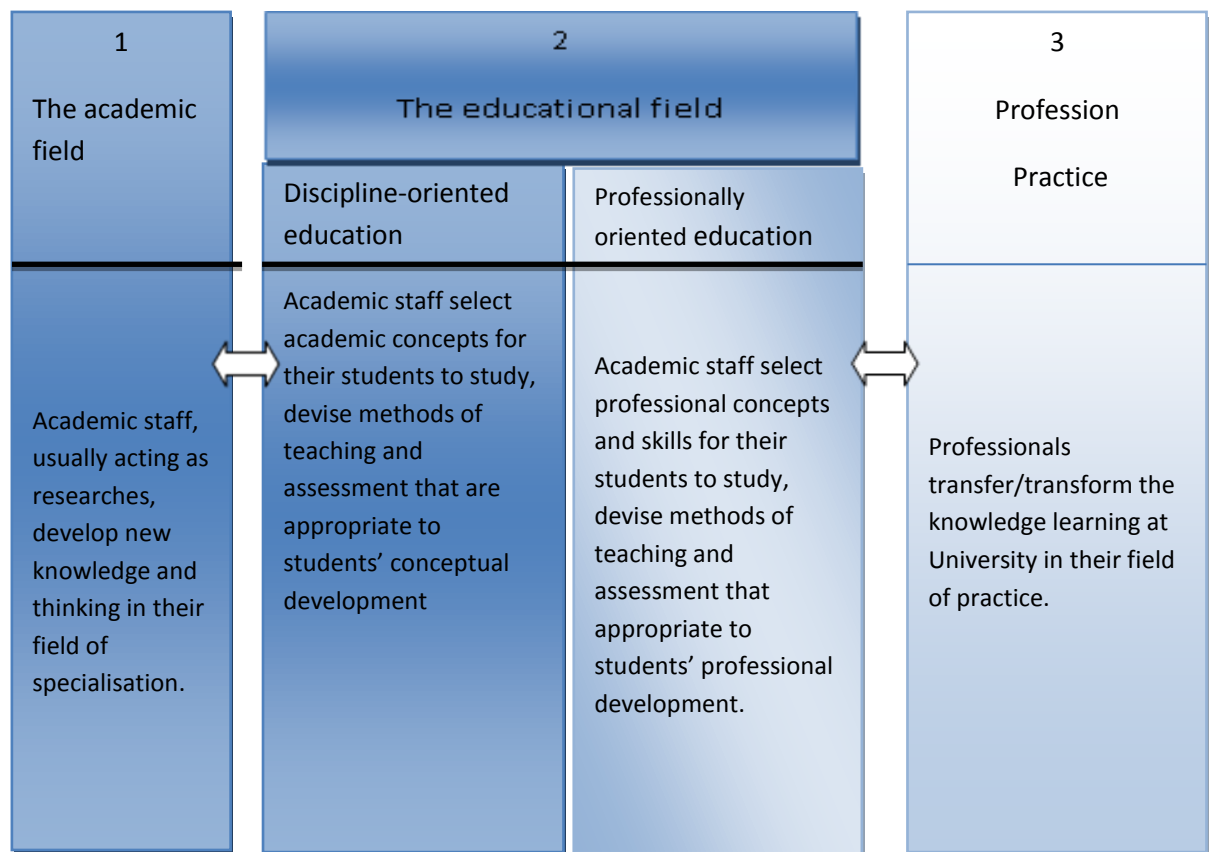


Figure 3.1: A conceptual framework for WIL (CHE, 2011)

The curriculum of PHC requires the students to correlate theory into practice, to achieve this students are expected to spend 960 hours in the professional practice as the requirement of the SANC. This is beneficial to the students as

the linkage between the world of teaching and learning, and the world of professional practice is built.

3.8.3 Limitations of the conceptual framework for WIL

The knowledge that is learned in a traditional academic lecture does not transfer to practice in the workplace in a straightforward manner or uncomplicated way. In practice knowledge is acquired in a more social way, through team work or mentoring and the basic skills can be transferred well but in a routine or habitual aspect of practice. The habitual practice may not correlate with the educational practice and that may hinder the professional growth of a student.

3.9 PILOT STUDY

Polit & Beck (2012: 195) define a pilot study as a small scale version or trial run designed to test the methods to be used in larger, more rigorous study. A pilot study was conducted with four PHC post basic nursing students namely two PHCI and two PHCII. It was done so as to assess whether the research question was realistic and workable, to identify logistical problems which might occur using proposed methods and to develop a research question and research plan. The results of the pilot study were that the interviewing skills of the researcher and the data analysis approach were acceptable. No changes were made after the pilot study. The pilot turned out to be a reassuring experience for the researcher

3.10 DATA ANALYSIS

In order to identify the emerging themes, the researcher personally analysed data under the guidance of the supervisor who is an expert in qualitative research. Tesch's eight-step procedure of data analysis was applied (Tesch, cited in Cresswell 2009: 186) as follows:

- Interviews was transcribed verbatim and analysed by the researcher
- The researcher read the transcripts and compared them with the audio-taped interviews
- The researcher read the transcript for the second time so as to identify the underlying meaning
- The researcher then selected the most interesting and informative interview and notes were made in the margins of the transcribed interview. The process was repeated for the rest of the interviews.
- Similar topics were then be clustered together under topics
- From these topics, the researcher then formed themes and sub-themes
- An experienced person in the field of qualitative research analysed the data separately and the identified themes were discussed with the researcher
- Literature was reviewed to verify the findings.

3.11 TRUSTWORTHINESS

As qualitative research has an element of subjectivity, and is open to criticism (Polit & Beck 2012:174), it is important that the study and the findings provide evidence of validity and reliability. Lincoln & Guba (1985: 289) suggest there is an alternative to validity and reliability that would provide the evidence for a decision trail and trustworthiness to be assured within qualitative research.

Trustworthiness refers to the extent to which a research study is worth paying attention to, worth taking note of and the extent to which others are convinced that the findings are to be trusted (Babbie & Mouton, 2001: 276). Lincoln & Guba (1985: 289) suggested four criteria for developing the trustworthiness of a qualitative inquiry. To ensure trustworthiness in this study, the following criteria were used:

3.11.1 Credibility

Credibility refers to confidence in the truth of data and interpretations of them (Polit & Beck 2012:175). To ensure credibility in this study notes were written during the interview. Information was probed during interviews until data was saturated and detailed notes were written immediately after the interview. Voice recordings were also done. To establish confidence in the truth of the findings, during report writing voice recordings were replayed repeatedly to ensure that all the information was transcribed. Following the interviews and their transcription, the researcher shared the transcripts with the participants for review and correction of the researcher's interpretation of the meaning of the data. The researcher bracketed existing knowledge, pre-conceived ideas and personal views regarding the existing problems in the clinical area.

3.11.2 Dependability

Dependability refers to the stability or reliability of data over time and conditions (Polit & Beck 2012: 175). Dependability is reliant on credibility. Data was collected from participants that had been exposed to clinical placement for a year. An audit trail was maintained through safe keeping of raw data of each interview for future reference. The audit involves a close scrutiny of the data collected and any supporting documentation by an external reviewer, in this case the supervisor. Although the researcher coded

the interviews herself, the data and analysis were checked for discrepancies scrutinised by the research supervisor who acted as an independent coder.

3.11.3 Confirmability

According to Lincoln & Guba (1985: 320-321), confirmability refers to the degree to which the researcher can demonstrate neutrality of the research interpretations. In qualitative research, confirmability focuses on the characteristics of the data gathered in the study and by utilising an audit trail. Following the transcription of the voice-recorded interviews, each participant was given an opportunity to review the transcribed interview and was asked to confirm if the notes were a true reflection of his/her views regarding the WIL experiences. Voice recordings were done to reflect the participant's voice. The researcher's interpretations were scrutinised by the research supervisor who acted as an independent coder. The themes and sub-themes identified by the researcher were contrasted with those identified by the supervisor. No major discrepancies were identified between the analyses of data.

3.11.4 Transferability

Transferability is the extent to which findings can be transferred to or have applicability in other settings or groups (Lincoln & Guba 1985: 321). To ensure transferability, there was rich and thorough description of the research setting, study participants and of the research processes.

3.12 ETHICAL CONSIDERATIONS

Approval of the study was sought from the Ethics Committee of the university that was studied (see Appendix 1) Permission to conduct a study was requested from the Director of Research (see appendix 2a and 2b), and the

Head of the Nursing Department of the university under study (see Appendix 3a & 3b), before data collection permission was requested and obtained from District Managers of Health District A and Health District B (see Appendixes 4a, 4b, 5a, 5b, 6a and 6b). Informed written consent was obtained from each participant (see Appendix 7).

Any qualitative study, like all the forms of research, is subject to a Codes of Ethics and good practice for the protection of the participants (Polit & Beck 2012: 152). Ethical codes are based upon a few generally accepted moral values of respect for individual beneficence, respect for human dignity and justice. To ensure ethical consideration these three broad principles on which standards of ethical conduct research are based were used (Polit & Beck 2012: 152).

3.12.1 Beneficence

According to Polit & Beck (2012: 152) beneficence imposes a duty on a researcher to minimise harm and maximise benefits. To adhere to this principle, the researcher needs to secure the well-being of the participants, be it physical, psychological, emotional, spiritual, economic, social or legal (Brink, van der Walt & van Rensburg, 2012: 36). The right to freedom from harm and discomfort was maintained as participants were not subjected to any risk of harm or injury. Before the study was conducted it was first approved by the University Research Committee and Provincial Department of Health of KZN, as well as the Health District authorities. The nature of the study, its importance and how it was going to be conducted was explained to the key contacts and the potential participants. The information about the purpose of the study, the process of data collection and analysis and how the results will be disseminated was discussed with the participants. The participants were

given opportunity to ask questions about the research procedure and the purpose before giving consent to be part of the research study. During interview the researcher ensured privacy by conducting interview in nurses' tea room far away from the patients. The participants were informed that they were free to discontinue their participation at any time during the study.

3.12.2 Respect for human dignity

Polit & Beck (2012: 154) describes self-determination as the right to participate or withdraw from the study. To enable the participants to make informed decision to participate in the study, the researcher provided detailed explanation on the study, including but not limited to the purpose of the study, consequences of participation or refusal to participate, and possible gains or risks associated with participating in the study. Following the full disclosure of information regarding the study, participants were asked to voluntarily sign a written consent to participate in the study. The researcher witnessed the signing and countersigned as witness.

3.12.3 Justice

Justice refers to fair treatment and the right to privacy (Polit & Beck 2012: 155). As part of the right to fair treatment, participants' selection should be based on study requirements and not on group vulnerability (Polit & Beck 2012: 155; Brink, van der Walt and van Rensburg, 2012: 36). To ensure that justice was maintained, the study population for the current study was all students registered in 2011 for Clinical Assessment, Diagnosis, Treatment and Care in a university that was studied. To ensure the right to privacy, data collected was kept in a private place that can only be accessed by the researcher. Participants' details were not written in the research report.

Participants had a right to give or not to give information. Anonymity and confidentiality were maintained by not recording participants' names and keeping the verbatim records under lock and key. The interviews were conducted in private settings chosen by each participant at their convenience. The right to self-determination was also maintained as participant had a right to ask questions, to refuse to give information and to withdraw from a study as indicated in the Information letter and consent.

3.13 CONCLUSION

This chapter described how the study was carried out and how data was collected. The sample chosen was appropriate for the data to be collected as it targeted people involved in the practice in some way or another. A qualitative research methodology and data triangulation was implemented. Chapter 4 will present the results of the study.

CHAPTER FOUR

PRESENTATION OF THE RESULTS

4.1 INTRODUCTION

The previous chapter presented research methodology. This chapter will present the results of the study. The aim of the study was to explore and describe PHC nursing students' experiences during clinical placements. All participants had experiences with clinical placement, as data was collected towards the end of the year in 2011 and students had enough exposure that enabled them to relate their experiences in clinical practice.

The nursing students had been exposed to clinical placement for a number of hours as the first year students are officially required to spend 388 hours while second year students have to spend 572 hours as per SANC regulation (R48). After analysis of the in- depth interviews with the PHC post basic nursing students, a thematic framework was used to categorize findings as they emerged and then organize them into themes with the intention of making the experiences meaningful and more measurable. The researcher was able to get both objective and subjective responses from the participants that provided both their professional and personal reflections on clinical placement. These responses were very useful in determining the extent of individual and collective experiences of student nurses during clinical placements.

The main research question was "What are the experiences of primary health care post basic nursing students regarding WIL?"

The researcher spent one week listening to tapes to familiarise herself with the data recorded before data transcription began. The researcher used different colours of highlighters to indicate codes and highlights on concepts and attributes that were similar. The researcher coded every script in order to develop a comprehensive framework for analysis. The comprehensive framework was then used for more detailed coding and thematic content analysis using manual methods. The researcher analysed all the transcripts. From an initial eight themes, the researcher continued to analyse content, merging relevant concepts and attributes until the themes were reduced to five.

4.2. MAJOR THEMES

After analysing data the following five themes were identified.

Theme 1: Shortage of staff

Theme 2: Inadequate material/ non-human resources

Theme 3: Lack of supervision in the clinical facilities

Theme 4: Distant clinical facilities

Theme 5: Insufficient practice in the clinical skills laboratory

These five themes and their sub-themes are presented in Table 4.1.

Table 4.1: Overview of the themes and the sub-themes

THEMES AND SUB-THEMES	
Theme 1	Shortage of staff
Sub-theme 1.1	Overcrowding at the clinics.
Sub-theme 1.2	Abseentism due to staff burnout and/ or ill-health
Sub-theme 1.3	High rate of attrition
Theme 2	Inadequate material/non-human resources
Sub-theme 2.1	Inadequate space.
Sub-theme 2.2	Inadequate equipment.
Theme 3	Lack of supervision in clinical facilities
Sub-theme 3.1	Participants were inadequately supervised due to shortage of staff.
Sub-theme 3.2	A mentor was not always available to supervise participants as she was always busy in the clinic.
Sub-theme 3.3	Trained nurses thought that supervision was a university's mentor's or lecturer's responsibility.
Sub-theme 3.4	Trained nurses felt there was no need for supervision as participants were already registered nurses.
Sub-theme 3.5	Registered nurses felt that participants were university students and knew everything so there was no need to supervise participants.
Theme 4	Distant clinical facilities
Sub-theme 4.1	Distant clinical facilities.
Sub-theme 4.2	Unreliable transport.
Sub-theme 4.3	Participants had to leave the clinic late to make up for the lost time in the morning.
Theme 5	Insufficient practice in the clinical skills laboratory
Sub-theme 5.1	Participants felt that practice in the CSL was inadequate.
Sub-theme 5.2	Clinical practice in the CSL did not give the participants an opportunity to identify abnormalities when doing health assessments as participants were practicing on each other.

4.3 DEMOGRAPHIC DATA OF THE PARTICIPANTS

A total number of ten participants were interviewed in two sampled districts. Their demographic characteristics are illustrated in table 4.2.

Table 4.2: Demographic data of the interviewed participants

Category	Health District A	Health District B
Number of participants		
Gender		
Female	6	4
Total	6	4
Level of study		
First year	2	2
Second year	4	2
Total	6	4
Location of the clinic		
Urban	2	3
Rural	4	1
Total	6	4

4.4 PRESENTATION OF THEMES AND SUB-THEMES

The results of this study are presented along the themes and sub-themes that were derived from the analysis of interviews. Five themes that emerged out of this study are presented in Table 4.1. Applicable direct quotes are provided to substantiate relevant results.

4.4.1 Shortage of staff

In the findings for this study, the participants reported that shortage of staff was a major challenge that crippled the efficient rendering of healthcare service and that also impacted negatively on student nurses during clinical placements. Shortage of staff led to trained nurses' inability to supervise participants. This is supported by the following statements:

"...the Unit Manager will say, 'please help me out as the clinic is overcrowded". (District B, Participant 2).

"...sometimes I am on my own as there is no one to assist me since the clinic is short staffed. Nurses are demoralised due to appalling conditions of service. As a result, nurses are often off-sick due to ill-health". (District B, Participant 1).

"...the clinic is short staffed as nurses are resigning to look for greener pastures in private practice and overseas countries". (District A, Participant 1).

Due to shortage of staff, registered nurses in the clinics expected the participants to work as trained staff in PHC because they needed extra people to help them. This is evident in the following excerpts:

"...oh you are here at least we have someone to help us to 'push the bench". (District B, Participant 1).

The participants also reported that they could not focus fully on their responsibilities during clinical placements as they also had to help out as well in other duties that had to be carried out in the clinics. This was obviously

demoralising to participants who had expected clinics to be a good environment for clinical placements as reflected in the excerpts below:

“The Operational Manager often says: ‘Trained nurses cannot leave patients and come to assist you. You have to try and do things on your own’....” (District A, Participant 2).

“...as students, we have to assist to push the bench until may be lunch time. Thereafter, you spend few hours to concentrate on what you have come for at the clinic”. (District B, Participant 2).

4.4.2 Inadequate material or non-human resources

Inadequate material or non-human resources were also cited by the participants of this study as one of the major challenges that compromised their learning in the clinical settings. The participants cited lack of space as one of the major challenge. The frustration of the participants is evident in the following participants’ voices:

“We are three students sharing one consulting room as there are inadequate consulting rooms for us to use”. (District B, Participant 3).

“We also have a problem of space in our clinic. The clinic offers many programmes that need privacy like voluntary counselling and testing for HIV, ante natal care, and mental health clinic. (District A, Participant 3)

Sometimes the consulting rooms were not available for students to do patient’s assessments

“On Wednesday the doctor uses the consulting room that we also use for consulting; so we do not have a place to conduct patients’ health assessments”. (District A, Participants 5 & 6).

Participants also verbalised that sometimes there was shortage of equipment, so students were unable to conduct proper patient assessment.

“.....at times we are allocated in consulting room that do not have couches”. (District B, Participant 3).

“The equipment is not readily available for us to use. Some of the consulting rooms have equipment that is not working”. (District A, Participant 5).

4.4.3 Lack of supervision in the clinical facilities

The university that is studied ensures that post basic nursing students are properly mentored through signing of mentoring agreements. However in this study it was noted that students still encountered challenges with regard to effective mentoring. Participants reported that they were on their own without a mentor to supervise them. In some cases a mentor was not always available for participants as she was always busy in the clinic, attending meetings or away due to personal reasons. This is evident in the following participants' voices:

“The mentor will say ‘I am unable to help you as you can see there are too many patients so I have to push the bench’...”. (District A, Participant 1)

“...as students, we help each other if we are stuck. We only call the mentor or a trained nurse if we need guidance with management of the patient”. (District B, Participant 3).

The participants also reported that trained nurses in the clinic were of the opinion that student supervision was the responsibility of a university mentor

or lecturer. Trained nurses were not keen to guide post basic nursing students or to answer students' questions. This is evident in the following participants' comments:

"...each time I ask a question, a trained Nurse would say 'ask your mentor, I do not have time'..." (District A, Participant 2).

"...in case I needed some information the trained Nurses would say: 'ask your lecturers on your lecture day'...." (District B, Participant 1)

The participants also mentioned that trained nurses in the clinical setting informed them that there was no need to supervise them as they were already qualified nurses and they knew everything. This is evident in the following participants' excerpts:

"I was only supervised on my first day at the clinic. On the next day I was given a consulting room to see patients as other trained PHC staff". (District B, Participant 1).

"As I am practising at the facility where I am permanently employed, staff members would tell me that there is no need to supervise me as I know what was what is happening at the clinic". (District B, Participant 2).

"...you are doing a post basic course at a university but you are asking from us. You should know". (District B, Participant 2).

Nurse educators are also expected to accompany the students in the clinical area to ensure that there is integration of theory and practice. However, in this study, the participants reported that regular accompaniment was not done. This is evident in the following participants' voice:

“I wish the university can allocate someone to accompany us. The clinics are at times busy and there is no one to support and guide us”.
(District B, Participant 1)

“...it could be better if the university would allocate a preceptor at a clinic to guide and support us...”. (District A, Participant 2)

4.4.4 Distant clinical facility

In this study participants also reported that one of their experiences were the distant clinical facilities. The participants reported that reaching the clinical placement facility was a problem as it is in the rural area and transport was unreliable. The participants had to leave too early for work and come back late. Participants had to sometimes leave the facility late so as to make up for the lost time if they arrived late in the clinic. These challenges experienced by the participants are reflected in the excerpts below:

“I have to travel from my work area to the clinical setting and it is quite a distance +-45km per single trip”. (District A, Participant 5)

“I sometimes arrive late at the clinic because of the long distance; as a result leave the clinic late so as to cover the required eight hours per day”. (District A, Participant 6)

“I wish the university can allocate us to nearby clinics that are around the city”. (District A, Participant 6)

Travelling is challenging as it is costly and exhausting, besides that it exposes travellers to risks such as road accidents, thus exposing students to stress and anxiety and that may affect students' concentration and performance.

“My first year was very stressful as I had to travel a long distance to the clinic and I arrived there very exhausted as I had to wake up early to arrive on time”. (District A Participant 5).

4.4.5 Insufficient practice in the clinical skills laboratory

Simulation in the clinical skills laboratory (CSL) gives a student an opportunity to master the skill before applying it in a live patient thus minimising risks and medico-legal hazards. At times, exposure to CSL hinders the students' ability to identify abnormalities that the real patient presents with. In this study, some participants reported that they felt comfortable to practice in the skills laboratory before exposure to real patients whereas others verbalised that they were not comfortable using the models as real patients. These participants reported that they failed to identify abnormalities if they came across these on real patients. This is noted in the quotes below:

“.....In the second year we were practising on each other in the CSL, so it was impossible to identify abnormalities as we were all healthy, so I wish practise can be done in real patients as we did in the first year.....” (District B, Participant 2).

“I wish that even in the second year clinical skills practice can be in the hospital like in the first year as things are better understood in the real situation”. (District A Participant 2).

The participants also reported that the time they spent in the CSL was not adequate for them to master a skill. This is verbalised in the following voices:

“I think the time that we spent in the CSL is not enough. I wish the institution can allow us to spend more time”. (District A, Participant 1).

“In the second year we were not given enough time to practice in the CSL, it was unlike the first year where we were given more time to practice”. (District A Participant 4).

4.5 CONCLUSION

In this chapter, the researcher was able to analyse the information derived from the interviews with the selected participants so that certain themes could be identified. Table 4.1 provides a summary of themes and sub-themes. The overall themes that emerged from the interviews were shortage of staff, inadequate material/ non-human resources, lack of supervision in the clinical facilities, distant clinical facilities and insufficient practice in the clinical skills laboratory. Chapter 5 will elaborate further by discussing these findings.

CHAPTER 5

DISCUSSION OF THE RESULTS

5.1 INTRODUCTION

In the previous chapter, the research results were presented and this chapter focuses on the discussion of the results. The discussion of the results is guided by the research question described in the first chapter, elements of the WIL conceptual framework as well as by the themes that emerged from the analysis of the interviews.

5.2 OVERVIEW OF THE RESEARCH DISCUSSIONS

The aim of this study was to explore and describe PHC post basic nursing students' experiences during clinical placements. In this study five major themes were identified, namely:

Theme 1: Shortage of staff

Theme 2: Inadequate material/ non-human resources

Theme 3: Lack of supervision in the clinical facilities

Theme 4: Distant clinical facilities

Theme 5: Insufficient practice in the clinical skills laboratory

These themes and their sub-themes are interpreted below and validated using relevant literature and the WIL conceptual framework to support the interpretation of the findings.

5.3 SHORTAGE OF STAFF

The findings of this study revealed that shortage of staff in the clinical facilities resulted in trained nurses being unable to supervise post basic nursing students. The WHO defines nursing shortage as a situation where the demand for nurses is greater than the supply (WHO, 2006). The discrepancy between demand and supply results in many patients not receiving proper care and also in nurses being overloaded with more duties than they cope with. Nursing shortage is considered as a global major barrier that affects the nurses' productivity, competency and their commitment to the health care organisation that they work for (Al Smadi 2009: 3; Jooste & Jasper, 2012: 59; Mokoka, Oosthuizen & Ehlers 2010: 9). The study that was done by Bhat, Giri & Kiokala (2010: 1) reveal that shortage of health workers is a massive problem globally but most intensely in developing countries. Furthermore, Vance (2011: 9) states that globally, nursing shortages are complex and projected to intensify in future due to an ageing workforce, declining number of enrolments at nursing schools and the perception that nursing offers fewer prospects than other careers. Ehlers (2003: 65) attests to this by arguing that the South African nursing shortage could be exacerbated by the retirement of the baby boomers born between 1943 and 1964.

The nursing shortage currently in the United States is a pressing issue in health care (Smith 2010: 3). Like many other countries in the world, Australia is grappling with a chronic shortage of registered nurses (Jackson, Mannix & Daly 2002: 42). Shortage of nurses has affected most countries if not all in Sub Saharan Africa, the numbers of nurses have declined substantially in recent years, for example in Malawi there have been a 12% reduction in available nurses, in year 2000 roughly 500 nurses left Ghana (Mills, Francis & Bonner 2005: 2). South Africa is also experiencing a serious shortage of nurses which has to be addressed to prevent the crises in health care

services (Mokoka, Oosthuizen & Ehlers 2010: 9). Joubert (2009: 2) further argues that shortage of nurses contributes to deaths in hospitals that would otherwise have been avoided; therefore the shortage of nurses is a matter of life and death.

There are many factors that contribute to shortage of staff in the nursing profession. Smith (2010: 2) mentions that the aging of registered nurses in the workforce is one of the causes of shortage of nurses in the United States. Job dissatisfaction is also considered as another cause of staff shortage (Jackson, Mannix & Daly 2002: 43). South Africa has a shortage of nursing staff that is due to emigration and nurses withdrawing from active practice (Smith 2010: 19). Jackson, Matrix & Daly (2002: 44) highlights that there are threats to the future supply of nurses as nursing is experiencing declining enrolments in undergraduate programs and this is a worldwide phenomenon. For sustained change and assurance of an adequate supply of nurses, solutions must be developed in several areas that is education and healthcare delivery systems (Nevidjon & Erickson 2001: 1).

The study that was done by de Beer, Brysiewicz & Bhengu (2011: 8) revealed that South Africa is facing a critical shortage of nurses. This has also affected even the critical areas in health like the Intensive Care Nursing (ICN) and has resulted in poor quality patient care (de Beer, Brysiewicz & Bhengu 2011: 8). The challenge of shortage does not only affect the hospitals but it also affects the PHC settings. The challenge of lack of personnel in PHC or the location of personnel in parts of a country with unmet needs affects every country in the world including USA (Byar, Kendall & Mogotlane 2012: 11). In Fiji, PHC programmes have faltered due to a shortage of health workers and funds among other factors (WHO Bulletin 2012). This is also evidenced by the

results of the study that was done by Asah (2010: 19) as it showed that skills are constantly lost from the district due to staff shortage.

To address the challenge of shortage of staff and in preparation for NHI implementation the government's most urgent task is to increase the number of health professionals who provide services and training and undertake health research (Republic of South Africa 2011: 14). To successfully address the challenge of shortage of nurses short, medium and long term initiatives must be put in place (Wildschut & Mqolozana 2008: 62).

5.4 INADEQUATE MATERIAL OR NON-HUMAN RESOURCES

Inadequate material or non-human resources were cited by the participants of this study as one of the major challenges that compromised their learning in the clinical settings. According to Mtshiya (2009 cited in Asah 2010: 20) shortage of equipment results to nurses having stress and being frustrated. Mongwe (2007: 101) states that shortage of resources could have a serious impact on the health care system and professional integrity could be jeopardized. This could also have a serious impact on the quality of experiences and learning of student nurses in the clinical learning environment.

Shortage of resources is a world-wide problem, the study that was done by Oikonomidou, Anastasiou, Dervas, Patri, Karaklidis, Moustakas, Andradou, Mantzanas, & Merkous (2010: 336) in Greece revealed that there is shortage of equipment in PHC and this needs to be addressed so as to improve the quality of care. This is also supported by the findings of the study on assessment of student nurses' clinical learning in Rwanda that was conducted

by Kayihura & Mtshali (2010: 104), which reports that lack of appropriate material resources is one of the challenges associated with clinical assessment strategies and assessment. It is also acknowledged by the researchers that it is difficult to work effectively in areas where resources are inadequate (Francis, Namafleh & Chapman 2005: 69). This is also evident by the findings of the study that was conducted by Mokoka et al. (2011: 160) which revealed that 94,4% of nurses in South Africa would consider remaining with their current employers if their institutions would ensure that they had adequate supplies and equipment.

Lack of space was also cited by the participants as one of the major challenge. Shortcomings in infrastructure are part of inequalities that keep rural communities in a disadvantaged position (Schoeman et al. 2010: 27). This affects delivery of health care above a certain level of complexity as it is difficult in the absence of good infrastructure (Lugte & Mbatha 2007: 2). Raol et al (2006 cited in Lugte & Mbatha 2007: 2) argue that poor infrastructure has been shown to significantly affect a patient's perception of quality of care and in South Africa has a significant effect on health professionals' satisfaction with their working conditions (Kotze & Couper 2007 cited in Lugte & Mbatha 2007: 2). The situational analysis that was done in KZN by Ndhlovu, Searle, Miller, Fisher, Synman & Sloans (2003: 23) showed that infrastructure at clinics proved to be less adequate than other facilities. These findings are supported by the findings of the study that was conducted by Sibiya (2009: 163-164) on integration of PHC services which cited lack of space and equipment as factors that hindered successful implementation of integrated PHC. According to the KZN Health Strategic Plan 2010-2014: 63, expansion of PHC services, including infrastructure projects is slowed down as a result of the over-expenditure and cost saving measures (KZN Department of Health, 2010).

The challenge of infrastructure is also a government's concern. The presentation on NHI pilot district selection that was done by the Dr A Motsoaledi on the 22nd of March 2012 states that to ensure access to quality health services and for NHI to succeed, The National Health Council agreed to allocation of funding for certain areas that have been considered to be non-negotiable and should be guaranteed in the provincial health budgets for 2012/2013. It is further stated that non-negotiable to be protected against underfunding. The non-negotiable includes essential equipment, maintenance of equipment and infrastructure to mention a few.

The issue of infrastructure was further discussed at a government level in a 2012 State of Nation Address by the State President where the whole nation was invited to join government in a massive infrastructure development drive. Refurbishment of clinics, hospitals and nurses home was identified as one of the critical social infrastructure projects as it aims at laying the basis for the NHI. However, according to the KZN Health Strategic Plan 2010-2014: 63, there are 30 gateway clinics in the province and fixed clinics increased from 450 in 2005 to 577 in 2008/9 and CHCs increased from 14 to 16 during the same period.

5.5 LACK OF SUPERVISION IN THE CLINICAL AREA

Lack of clinical supervision was also reported by the participants as a challenge. The participants reported that trained nurses in the clinical setting informed them that there was no need to supervise them as they were already qualified nurses and they knew everything. This is further supported by the findings of the study that was conducted by Pillay & Mtshali (2008: 48) where the students reported that they did not receive academic support because unit staff perceived them to be a burden in the clinical area. They regarded post

basic nursing students as old nurses with experience. These authors further state that it is difficult to establish supervision without dedicated support.

According to Lewis (1998: 221), supervision is a process based on a clinically focused professional relationship between the practitioner engaged in clinical practice and a clinical supervisor. Supervision allows student nurses to focus on personal and professional strengths and difficulties. Bond & Holland (1998: 12) maintain that the role of supervisors is to facilitate the growth of student nurses, both educationally and personally. Brown (1999: 49) indicates that mentoring is a relationship between two people in which one with greater rank, experience, and/or expertise teaches, counsels, guides and helps the other to develop both professionally and personally. Gray & Smith (2000: 1543) indicate that a good mentor possesses appropriate professional attributes, knowledge, good communication skills and the motivation to teach and support students. Brown (1999: 49) reports that helpful mentorship activities, as indicated by mentees, include that mentors should be available, should be good listeners and should provide feedback to mentees. This is further supported by the findings of the study that was conducted by Monareng, Jooste & Dube (2009: 113) which state that preceptors should focus on identifying learning needs of students. They could do so by holding planning meetings with students to determine their needs.

The participants in this study also reported that nurse educators did not conduct regular accompaniment. The SANC (2011: 2) defines 'accompaniment' as the directed assistance and support extended to a student by a registered nurse with the aim of developing a competent, independent practitioner. During accompaniment student nurses expect to be developed as indicated by the SANC. Nurse educators are charged with the

responsibility of bridging the gap between the worlds of academia and service in clinical settings during accompaniment of student nurses. It may be essential for nurse educators to be involved in the presentation of theory and practice which can facilitate the integration of theory and practice by student nurses during clinical placement and accompaniment. However, the findings of the survey that was conducted by Fundisa at university nursing schools that offer pre-registration nursing degrees revealed that there is no structured way in which nurse academics are required to keep themselves clinically competent (Fundisa, 2012: 71). This could be attributed to poor clinical accompaniment by nurse educators.

According to Cahill (1997: 149), nurse educators should have time to develop and maintain their clinical skills and to be involved in clinical teaching for one day per week. Nurse educators should also ensure that learning objectives are met by liaising with unit supervisors supporting both these supervisors and the student nurses. However, it is worth-noting that in South Africa, there is gross shortage of nurses as earlier discussed. The KZN Health Strategic Plan 2010-2014 states that the professional nurse clinical workload in PHC setting is 40 patients per day. This exceeds the national target of 35 patients per day. Hall (2004 cited in Jooste & Jasper (2012: 58) further argues that nurse managers in clinics have experienced high workload due to high proportions of patients with AIDS-related diseases and the time-consuming care required. Lack of clinical supervision of PHC students as revealed by this study could be attributed to the increased PHC nurses work.

5.6 DISTANT CLINICAL FACILITIES

Distant clinical facilities were also reported as a challenge that the students experienced during clinical placements. This was experienced in the facilities that are located in rural areas where there is poor infrastructure and lack of transportation. According to Killam & Carter (2010: 7) infrastructure and transportation factors can affect the students' ability to get to clinical placement timeously and can cause considerable anxiety for the student. Nursing students are placed in the clinical facility to ensure that they meet the learning outcomes and become competent in the skills they need to acquire and to master. PHC post basic nursing students are expected to spend 960 hours in clinical placement as a requirement by SANC (SANC 1997). It is the responsibility of a Nursing Education Institution (NEI) to identify relevant clinical sites and to allocate students in those clinical sites however the clinical setting has to be approved by the SANC.

According to the Provincial Government of the Western Cape Department of Health (2009: 12), the SANC has incorporated the accreditation of clinical learning facilities as a compulsory component for all NEIs, meaning that students cannot be placed in any clinical setting no matter how convenient it is for the student unless accredited by SANC. The Provincial Government of the Western Cape Department of Health (2009: 12) further states that the clinical facility has to meet certain requirements or standards for it to be accredited thus not all clinical facilities are accredited for students' placement. The limited number of accredited clinical facilities poses a challenge to some nursing students as they have to travel long distances for them to reach clinical placements (Killam & Carter 2010: 7). This causes inconvenience as travelling is costly and exhausting. Travelling long distances also causes delays that result in late coming.

5.7 INSUFFICIENT PRACTICE IN THE CLINICAL SKILLS LABORATORY

Whilst some participants reported that they felt comfortable to practice in the CSL before exposure to real patients, few participants verbalized that they were not comfortable using the models as real patients. These participants reported that they failed to identify abnormalities if they came across these on real patients. According to Ncama & Cassimjee (2005 cited in Saakane, John, Shaahidi, Maphosa, Jennifer & Petra 2007: 362), a CSL is a student oriented learning environment that provides resources for the learning of the clinical skills applicable to nursing practice. A clinical skills laboratory contains a range of models, diagnostic and therapeutic equipment (Omer, Amir & Ahmed 2008: 29). The clinical skills laboratory helps the student to learn and practice basic skills in preparation for the administration of quality care to the consumer. A specific time is assigned for students to practice in the clinical skills laboratory.

In the CSL students practice skills under guidance or supervision of a Lecturer or Clinical Instructor. In the CSL students are given an opportunity to practice skills as much as they can, they also get a chance to practice with models and equipment as there is no life threatening risk. According to College (2006 cited in Saakane et al (2007: 360) nursing skills laboratories provide a supportive and caring environment for students to practice and demonstrate nursing skills before moving into the practice setting with patients. In the skills laboratory students learn clinical, communication and information technology skills to a specified level of competence prior to direct contact with the patient (Omer, Amir & Ahmed 2008: 29). The CSL is beneficial to a student as she can feel at ease to learn at her own pace and to rehearse the skill more frequently before being exposed to a real situation. Omer, Amir & Ahmed

(2008: 98) refers to the CSL as protected learning environment with no distress and where mistakes are permissible.

Although the CSL has become an essential structure in nurse education, several benefits of its use have been identified. Literature shows that there are challenges regarding the use of CSL such as lack of supervision due to a large number of students (Omer, Amir & Ahmed 2008: 98), inappropriateness of certain skills to be practised in the CSL, for example blood glucose monitoring where a student has to prick herself to get a blood sample (Saakane et al 2007: 364), students' inability to transfer the skills learned in CSL into the reality of practice especially in invasive procedures (Widyandana, Majoor & Scherpbier 2010: 2).

5.8 CONCLUSION

The findings of this study revealed that WIL is vital for the development of clinical skills amongst PHC post basic nursing students. However, shortage of staff, inadequate material/ non-human resources, lack of supervision in the clinical facilities, distant clinical facilities and insufficient practice in the clinical skills laboratory were identified as challenges that students experience during WIL placement.

5.9 LIMITATIONS

The study findings are limited in that purposive sampling was done and the study was conducted in one university; therefore, the findings cannot be generalized to different universities. The findings of this descriptive qualitative

study though not generalizable, may provide further information on the WIL experiences of nursing students in the clinical facilities. Since interviews were conducted in English, there is a risk that despite being fluent in the language, participants whose home language is isiZulu may have had difficulty in expressing their thoughts and feelings. In spite of the limitations of the study, it does meet the objectives set out in the beginning by exploring PHC post basic nursing students' experiences during clinical placements.

5.10 RECOMMENDATIONS

Based on the findings of the study, the following recommendations were made with special reference to nursing education, institutional management and practice, policy development and implementation and further research.

5.10.1 Nursing education

As discussed in chapter 2, the Department of Health has adopted the three stream approach to PHC re-engineering programme which has been proved to be a success in other countries, the model contains a ward based PHC outreach team, consisting of both nurses and community health workers. To successfully engineer its PHC system South Africa will need more professional nurses especially PHC nurses.

During clinical placement, PHC students' needs to be mentored so as to develop clinical and diagnostic reasoning. This is achieved through instruction and guidance by lectures, mentors and clinical staff (Lekhuleni, van Der Wal & Ehlers 2004: 15) Therefore this study recommends that meaningful collaboration be ensured between Nursing Education and Health Care

Delivery System to encourage the alignment in the goal which is critical to the joint success and Faculty members to work closely with clinical nurse managers so as to be able to tackle challenges successfully.

The findings of this study revealed that there was lack of supervision by Lecturers in the clinical facilities as regular accompaniment was not done. To ensure that students are able to correlate theory into practice and are supported academically nurse educators have to do accompaniment. It is also recommended that the university under study develop more visionary and organised approaches to nursing education.

Insufficient and inappropriate skills practice in the CSL were also revealed in the findings of this study as student were unable to identify abnormalities as they practised on each other, that is healthy people. This study recommends that abnormal skills sessions be done in real clinical situation per arrangement with clinical facilities. It is also recommended that university under study purchase advance manikins that simulate real situation depending on affordability.

The researcher recommends that an intensive orientation of students should be done before they are placed in the clinical area in order to lessen the burden on staff at the clinical site. Part time employment of clinical instructors by the university under study is recommended so as to assist with clinical accompaniment.

Distant clinical facilities were also reported as a challenge that the students experienced during clinical placements. The limited number of accredited clinical facilities poses a challenge to some nursing students as they have to travel long distances for them to reach clinical placements (Killam & Carter 2010: 7). This causes inconvenience as travelling is costly and exhausting. Travelling long distances also causes delays that result in late coming. The researcher recommends that clinical placement, facilities' accreditation and placement potential problems be discussed with the students on orientation. The university under study must explore more clinical facilities around the university that are appropriate for the achievement of the programmes outcomes.

5.10.2 Measures to enhance learning in the clinical practice

Implementation of the proposed model for the clinical nursing education and training is recommended in order to improve clinical preparation of nurses. The Nursing Education Stakeholders indicated that a task team be appointed to champion the implementation of this model (Fundisa, 2012: 12). A rigorous process of appointing a preceptor must be followed so that a suitable person is allocated to supervise and guide the students. The university under study must ensure that clinical accompaniment is done accordingly that is, a lecturer must spend at least one hour fortnightly with each student as specified by SANC. An accurate record of clinical accompaniment must be kept so as to be able to track and monitor student accompaniment. Clinical placement evaluation should be conducted at regular intervals to measure student satisfaction with the venue. Regular meetings with stakeholders and continual feedback on performance and students' practice are also recommended.

Clinical learning takes place in a clinical setting. Therefore, PPE is essential. Therefore, students must be placed for practicals only in identified PPEs (Fundisa Series, 2012: 55).

5.10.3 Policy development and implementation

Although efforts have been made to retain valuable skill in the country through the introduction of community service, financial incentives like rural and scarce skills allowances and Occupation Specific Dispensation (OSD), staffing still remains a challenge. There must be a clear policy on human resources that will include strategies for dealing with migration of health personnel to developed countries (Sibiya, 2009: 194).

5.10.4 Further research

The researcher recommends that further research be done on the experiences of the lecturers, clinical facilitators and clinical supervisors regarding the views in clinical facilitation.

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Appendix 1: University Clearance



D U R B A N
UNIVERSITY of
TECHNOLOGY

Appendix 1: University Ethics Clearance

INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC)

16 November 2011

IREC Reference Number: REC 2/11

Mrs N E Sibiya
29 Jordaan Road
Westgate
Pietermaritzburg
3201

Dear Mrs Sibiya

Work Integrated Learning Experiences of Primary Health Care Post Basic Nursing Students in Clinical Settings.

I am pleased to inform you that Full Approval has been granted to your proposal REC 2/11 subject to the following amendments:

- Data Collection: replace "scribbled down" with "written by researcher."
- Appendices: labelling of appendices is suggested as follows:
 - Appendix 1a: Letter of Permission: District Manager- eThekweni District
 - Appendix 1b: Letter of Permission: District Manager- uMgundlovu District
 - Appendix 1c: Letter of Permission: Dean of Students- DUT
 - Appendix 1d: Letter of Permission: HOD- Nursing

The Proposal has been allocated the following Ethical Clearance number IREC 004/11. Please use this number in all communication with this office.

Approval has been granted for a period of one year, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's. In addition, you will be responsible to ensure gatekeeper permission.

Please note that ANY amendments in the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Appendix 2a: Letter of Permission

The Research Director
Durban University of Technology
PO Box 1334
Durban
4000

18 November 2011

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am presently registered as a Masters student at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: '*Work integrated learning experiences of primary health care post basic nursing students in clinical settings*'. The aim of the study is to explore the experiences of Primary Health Care nursing students during clinical placements so as to address the challenges that they are faced with in the clinical setting. In-depth interviews will be conducted with students to collect data.

I hereby request your permission to collect data from students that are currently registered for Bachelor's Degree in Technology: Nursing (Primary Health Care) in your institution. My research proposal has been attached for your perusal. Your support and permission to conduct the study at your institution will be appreciated.

Yours sincerely

.....
NE Sibiya (Mrs)
M Tech student
Contact number: 082 787 7228
Email address: nontuthuzelos@dut.ac.za

.....
MN Sibiya (Dr)
Supervisor
Contact number: 031-3732 2606
Email address: nokuthulas@dut.ac.za

Appendix2b



D U R B A N
UNIVERSITY of
TECHNOLOGY

Appendix 2b: Letter of Approval from the Research Director

*Directorate for Research and Postgraduate Support
Durban University of Technology
Trompsburg Annex, Steve Biko Campus
P.O. Box 1334, Durban 4000
Tel.: 031-3732578/7
Fax: 031-3732948
E-mail: moyos@duut.ac.za*

22nd November 2011

Mrs NE Sibiya
c/o Department of Nursing
Durban University of Technology

Dear Mrs Sibiya

PERMISSION TO CONDUCT RESEARCH AT THE DUT

Your correspondence dated 18th November 2011 in respect of the above refers. I am pleased to inform you that the Institutional Research Committee (IRC) will grant permission to you to conduct your research at the Durban University of Technology.

We would be grateful if a summary of your key research findings can be submitted to the IRC on completion of your studies.

Kindest regards.
Yours sincerely



PROF. S. MOYOS
DIRECTOR (ACTING): RESEARCH AND POSTGRADUATE SUPPORT



Appendix 3a: Letter of Permission

The Head of Nursing Department
Durban University of Technology
Durban
4000

18 November 2011

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am presently registered as a Masters student at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: '*Work integrated learning experiences of primary health care post basic nursing students in clinical settings*'. The aim of the study is to explore the experiences of PHC nursing students during clinical placements so as to address the challenges that they are faced with in the clinical setting. In-depth interviews will be conducted to collect data.

I hereby request your permission to collect data from students that are currently registered in your department for Bachelor's Degree in Technology: Nursing (Primary Health Care). My research proposal has been attached for your perusal. Your support and permission to conduct the study in your department will be appreciated.

Yours sincerely

.....
NE Sibiya (Mrs)
M Tech student
Contact number: 082 787 7228
Email address: nontuthuzelos@dut.ac.za

.....
MN Sibiya (Dr)
Supervisor
Contact number: 031-3732 2606
Email address: nokuthulas@dut.ac.za

Appendix 3b: Letter of Approval from HOD

Appendix 4a: Letter of Permission

The District Manager
EThekweni Health District
Mayville
4000

18 November 2011

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am presently registered as a Masters student at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: '*Work integrated learning experiences of primary health care post basic nursing students in clinical settings*'. The aim of the study is to explore the experiences of PHC nursing students during clinical placements so as to address the challenges that they are faced with in the clinical setting. In-depth interviews will be conducted to collect data.

I hereby request your permission to conduct a research project at your clinics. My research proposal has been attached for your perusal. Your support and permission to conduct the study at your facility will be appreciated.

Yours sincerely

.....
NE Sibiya (Mrs)
M Tech student
Contact number: 082 787 7228
2606
Email address: nontuthuzelos@dut.ac.za

.....
MN Sibiya (Dr)
Supervisor
Contact number: 031-3732
Email address: nokuthulas@dut.ac.za

Appendix 4b



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Postal Address: Private Bag X54318 Durban 4000
ss: 83 Jan Smuts Highway, Mayville, Durban 4001
Tel: 031 2405308; Fax: 031 2405500
Email: nan.hoosain@kznhealth.gov.za
www.kznhealth.gov.za

Appendix 4b: Letter of Approval from the Department of Health District A

Enquiries: Ms P Dladla
Date : 12 December 2011

Mrs N E Sibiya
29 Jordaan Road
Westgate
Pietermaritzburg
3201

REQUEST TO CONDUCT RESEARCH:
Work integrated learning experiences of primary health care post basic nursing students in clinical settings

I have pleasure in informing you that permission has been granted to you by the District Manager to conduct research on the above research study.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regard to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Acting District Manager
eThekweni
Telephone: 031 2405308
Fax : 031 2405500
Email : nan.hoosain@kznhealth.gov.za

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 5a: Letter of Permission

The District Manager
UMgungundlovu Health District
Pietermaritzburg
3201

18 November 2011

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am presently registered as a Masters student at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: '*Work integrated learning experiences of primary health care post basic nursing students in clinical settings*'. The aim of the study is to explore the experiences of PHC nursing students during clinical placements so as to address the challenges that they are faced with in the clinical setting. In-depth interviews will be conducted to collect data.

I hereby request your permission to conduct a research project at your clinics. My research proposal has been attached for your perusal. Your support and permission to conduct the study at your facility will be appreciated.

Yours sincerely

.....
NE Sibiya (Mrs)
M Tech student
Contact number: 082 787 7228
031-3732 2606
Email address: nontuthuzelos@dut.ac.za
nokuthulas@dut.ac.za

.....
MN Sibiya (Dr)
Supervisor
Contact number:

Email address:

Appendix 5a: Letter of Permission

The District Manager
UMgungundlovu Health District
Pietermaritzburg
3201

18 November 2011

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am presently registered as a Masters student at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: '*Work integrated learning experiences of primary health care post basic nursing students in clinical settings*'. The aim of the study is to explore the experiences of PHC nursing students during clinical placements so as to address the challenges that they are faced with in the clinical setting. In-depth interviews will be conducted to collect data.

I hereby request your permission to conduct a research project at your clinics. My research proposal has been attached for your perusal. Your support and permission to conduct the study at your facility will be appreciated.

Yours sincerely

.....
NE Sibiya (Mrs)
M Tech student
Contact number: 082 787 7228
031-3732 2606
Email address: nontuthuzelos@dut.ac.za
nokuthulas@dut.ac.za

.....
MN Sibiya (Dr)
Supervisor
Contact number:
Email address:

Appendix 5b: Letter of Approval



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

**UMGUNGUNDLOVU HEALTH DISTRICT OFFICE
OFFICE OF THE DISTRICT
MANAGER**

Private Bag X9124,
Pietermaritzburg, 3200
Brasfort House, 262 Langalibalele
Street, Pietermaritzburg, 3201
Tel.: 033-8971000,
Fax: 033-897 1078
Email.: thule.kunene@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Mrs. N.M. Zuma - Mkhonza

Ref No: 15/16

Date: 30 November 2011

**TO: MRS N E SIBIYA
M TECH STEDENT**

**RE: PERMISSION TO CONDUCT A RESEARCH IN WORK INTEGRATED LEARNING
EXPERIENCES OF PRIMARY HEALTH CARE POST BASIC NURSING STUDENTS IN
CLINICAL SETTINGS**

Your correspondence regarding the permission to conduct a **Research In Work Integrated Learning Experiences Of Primary Health Care Post Basic Nursing Students In Clinical Settings**

I have pleasure in informing you that permission has been granted to you by the District Office to conduct your research

PLEASE NOTE THE FOLLOWING

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Thank you

Original document signed by the District Manager and a copy is available on request

**MRS N.M. ZUMA - MKHONZA
DISTRICT MANAGER
UMGUNGUNDLOVU HEALTH DISTRICT**

Appendix 6a: Letter of Permission

The Research Team
330 Langalibalele Street
Natalia Building
Pietermaritzburg
3200

12 December 2011

The Research Team

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am presently registered as a Masters student at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: '*Work integrated learning experiences of primary health care post basic nursing students in clinical settings*'. The aim of the study is to explore the experiences of PHC nursing students during clinical placements so as to address the challenges that they are faced with in the clinical setting. In-depth interviews will be conducted to collect data.

I hereby request your permission to conduct a research project at eThekweni and UMgungundlovu Districts. The students are currently placed in the following PHC facilities:

EThekwini District	UMgungundlovu District
Prince Mshiyeni Memorial Hospital Gateway Clinic	Edendale Hospital Gateway Clinic
Addington Hospital Gateway Clinic	East Boom Clinic
L Clinic Umlazi	Imbalenhle CHC
AA Umlazi Clinic	PMB City Central
G Umlazi	
Rydavale Clinic	
Magabheni Clinic	
Hlengisizwe CHC	
Umsunduzi Clinic	
Glenhill Clinic	
Inanda CHC (Public)	

.....

NE Sibiya (Mrs)

M Tech student

Contact number: 082 787 7228
031-3732 2606

Email address: nontuthuzelos@dut.ac.za
nokuthulas@dut.ac.za

.....

MN Sibiya (Dr)

Supervisor

Contact number:

Email address:

Appendix 6b: Approval letter from KZN DoH



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hkrm@kznhealth.gov.za
www.kznhealth.gov.za

Appendix 6b: Letter of Approval from the Department of Health Head Office

Reference : HRKM13/12
Enquiries : Mrs G Khumalo
Telephone : 033 – 3953189

23 January 2012

Dear Mrs N E Sibiyi

Subject: Approval of a Research Proposal


1. The research proposal titled 'Work integrated learning experiences of primary health care post basic nursing students in clinical settings' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at selected facilities at Umgungundlovu & eThekweni districts.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hkrm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely


Dr E Lutge
Chairperson, Health Research Committee
KwaZulu-Natal Department of Health
Date: 21/01/2012

uMnyango Wezempilo. Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 7: Letter of Information and Consent

Title of the Research Study: Work integrated learning experiences of primary health care post basic nursing students in clinical settings

Principle Investigator : Mrs NE Sibiya
Supervisor : Dr MN Sibiya

Dear Participant

Thank you for taking time to read this information letter. I am a Master's Degree student and in order to qualify, I am required to complete a research dissertation. With your assistance and co-operation, I will be able undertake this research study. The details are outlined below:

Brief Introduction and Purpose of the Study: Clinical placement is an essential component in primary health care (PHC) course as required by the South African Nursing Council. This is achieved through instruction and guidance by lecturers, mentors and clinical staff. However it has been noted that the clinical learning environment may confront you with challenges that are absent from the classroom situation. This may expose you to various experiences. Therefore, this study seeks to explore your experiences as a nursing student in PHC settings.

Research Design: I am requesting that you allow me to interview you for approximately 45 minutes. I request for permission to record the interview and the recordings will be kept in a safe place and will be destroyed after a period of 5 years. Please note that the interviews will be recorded for the purposes of later transcription.

Risks or Discomforts to the Subject: You will not be subjected to any risk or discomfort.

Benefits: This study seeks to explore your experiences in the clinical area so as to address the challenges that you may be faced with. This would ultimately improve the efficiency of health service delivery in PHC clinics. The findings of this study will be shared with you for verification purposes and thereafter will be published in journals.

Remuneration: There is no remuneration for participating in this study.

Costs of the Study: None

Confidentiality: All data collected will be strictly private and confidential and will only be used for the purpose of the study. No information will be linked to your identity.

Research-related Injury: You will not be subjected to any risk or discomfort.

Persons to Contact in the Event of Any Problems or Queries:

Mrs NE Sibiya : 082 787 7228

Dr MN Sibiya : 031-373 2606

Statement of Agreement to Participate in the Research Study:
(Statement of Agreement to Participate in the Research Study:

I-----subject's full name, have read this document in its entirety and understand its contents. Where I have had any questions or queries, these have been explained to me to my satisfaction. Furthermore, I fully understand that I may withdraw from this study at any stage without any adverse consequences and my future health care will not be compromised. I, therefore, voluntarily agree to participate in this study.

Subject's Name-----Signature-----Date-----

Researcher's Name-----Signature-----Date-----

Thank you for your assistance.

Department of Nursing, Durban University of Technology

Appendix 8: Mentoring agreement

I (full name)

.....

agree to mentor (full name)

.....

a Primary Health Care nursing student from the Durban University of Technology. I have read the requirements for mentoring and agree to comply with these requirements.

Signed

.....

Student Date

On behalf of the Durban University of Technology, I would like to thank you for agreeing to mentor our Primary Health Care nursing student. The student will be required to undertake 960 hours of experiential learning in clinical skills in order to meet the requirements leading to the registration of the Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care with the South African Nursing council. A portion of these hours i.e. 360 hours will be undertaken in a primary health care clinic. During this time you will be required to mentor the student.

On arrival at the clinic, the student will have completed the lectures that enable him/her to do a complete adult health assessment. During the course of the year, the student should refine the practical skills which allow him/her to be competent in doing health assessment.

For the first few clinic visits, the student may need to observe you as you consult with and examine patients. Thereafter, the student must be allowed to undertake this process during which, you observe the student. Once the student is competent, the student must be allowed to undertake the consultation and examination on their own. However, it must be noted that the student practices under your authority. For this reason, each case that the student undertakes must be presented to you, prior to the final management decisions, for your agreement and approval.

The lecturers undertaking clinical supervision for the Nursing Programme will visit the student from time to time. During this time, the student will be observed, assessed and supported in the clinical setting.

If you have any further questions regarding your role as mentor or general questions regarding the programmes, please do not hesitate to contact the lecturer, Dr Nokuthula Sibiyi at 031-373 2032. We thank you for your support.