THE ASSESSMENT OF THE FACILITATION OF THE CLINICAL TRAINING COMPONENT OF AN UNDERGRADUATE NURSING PROGRAMME AT A UNIVERSITY OF TECHNOLOGY.

BY: N.P. XABA

STUDENT NUMBER: 21242194

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INSTITUTION: DURBAN UNIVERSITY OF TECHNOLOGY

SUPERVISOR: PROF. J. K. ADAM

CO-SUPERVISOR: MRS B.T. MKHIZE

DECLARATION

I, Nompumelelo Pearl Xaba, do hereby declare that this study is representative of my work. Where the work of others was used, has been acknowledged accordingly in the text.

[redacted]

Signature of student

12/11/14

Date of signature

APPROVED FOR FINAL SUBMISSION

[redacted]

Prof J. K. Adam

12/11/14

Date of signature

D TECH: CLINICAL TECHNOLOGY

[redacted]

Mrs B.T. Mkhize

12/11/14

Date of signature

M TECH: BIOMEDICAL TECHNOLOGY

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ABSTRACT

BACKGROUND

All nursing students need to undergo clinical training for them to be competent practitioners when they qualify. According to the South African Nursing Council (SANC) training facilities are accredited only if the clinical training component is effective. Therefore, it is important that students are accompanied in order for them to grow professionally and have values as future health care professionals. In nursing education, a student throughout the nursing training course receives instruction both theoretically and clinically in the subjects prescribed in the curriculum by the SANC. Clinical instruction is effected through clinical teaching and learning, which is a requirement by the nursing regulatory body, the SANC. For an undergraduate programme a student has to spend a minimum of 1000 hours per year in clinical placement to meet programme outcomes. It is the responsibility of all nursing schools, colleges and universities to ensure that each student meets these requirements. For this to be effective it has to be facilitated by lecturers and clinical instructors, through teaching and learning strategies to enable students to perform the clinical skill with knowledge and eventual competence. Therefore, clinical instructors are there to ensure that the students are competent in all skills, such as cognitive, affective as well as psychomotor skills. This will be beneficial to the programme in reduction of rates of failure and dropout and again by producing competent practitioners. A positive relationship and collaboration between the clinical training institutions and clinical placement facilities is vital for student achievement, especially because the clinical instructors assist students in correlating theory and practice. This study sought to assess the clinical training component of an undergraduate programme at this UoT in KwaZulu Natal. Findings may inform an improved clinical instruction programme as no such study had been undertaken.

METHODS

A qualitative and quantitative design was used to explore feelings, perceptions as well as experiences of staff and student nurses with regard to clinical training component. Stratified random sampling was used to select student nurses according to levels of training and questionnaires were used to collect data. All permanently

employed staff who had been working over six months were selected since they were directly or indirectly involved in the clinical facilitation. A focus group interview was conducted for the clinical instructors and questionnaires were used for the lecturers to collect data. Themes and sub-themes emerged and on analysis they were compared to the findings from the quantitative survey.

RESULTS AND DISCUSION

The results revealed that collaboration of clinical placement facilities and training institutions is important for student's support since all parties are able to communicate freely and students benefit. Students stated that they did not get enough support since the clinical facilitators were short staffed and they were also allocated to facilities that were far from the campus. The respondents cited problems during clinical accompaniments as there were very high expectations by staff members in the placement areas regarding student support. Lecturers were also expected to involve themselves in clinical accompaniment to bridge theory-practice gap. The employment of mentors will assist in student support as the mentors will be at placement areas and the staff and students easily contact them.

CONCLUSION

From the interviews the researcher managed to come up with important aspects that should be included in an accompaniment tool when developed, which should be user friendly to both lecturers and clinical facilitators. It will thus assist students with critical skills including critical thinking when performing any patient related nursing skill. It was recommended that the UoT management support staff by attending to their concerns including finding more clinical placement facilities close to the campus.

Key words: clinical facilitation; clinical accompaniment; clinical teaching; clinical placement education model; collaboration; clinical facilitator: ratio; student accompaniment tool.

DEDICATION

Firstly I would like to thank God almighty for granting me the opportunity to realise my dream as well as the strength to stick on this journey even when it was tough and I did not think I will finish. Therefore I would like to dedicate this dissertation to my late mother Maureen Ntombizodwa Ndaba, who contributed to where I am today by raising me the way she did (may her soul rest in peace), she taught me that for everything you want in life you have to work very hard for it. I also would like to thank my loving husband for being supportive and patient with when I was busy with my research, my beautiful children Sinakhokonke, Sbongakonke Xaba and my niece Ntandoyenkosi Ndaba who have been there for me and very supportive during the course of my study, without them I wouldn't have been eager to continue and finish this tough journey. They used to massage my feet and cook for the family while I was very busy. Not forgetting my helper Jabu who took care of my children and the house without supervision during this period. I love you all so much.

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DEFINITION OF TERMS

- According to the SANC (2011), **clinical accompaniment** is a structured purpose by a Nursing Education Institution to facilitate assistance and support to the student nurse education a clinical facility to ensure the achievement of the programme outcome.

- **Clinical facilitation** is defined by Mellish et al. (1998) as a process applied by a lecturer in a clinical teaching and learning situation.

- **Clinical facility** according to SANC it is a health facility with a primary purpose of providing care to patients and is also used to teach clinical skills to learners.

- **Clinical instructor/facilitator** is a professional nurse that the nursing school or clinical setting employs for the purpose of clinical teaching. (Bruce et al., 2011). According to the SANC, R425(1985) clinical facilitator/instructor refers to a nurse educator who is employed as a tutor in the Nursing College and who is responsible for both the theoretical component and clinical facilitation for the basic nursing and training programme leading to registration as a nurse (general, psychiatric and community) and midwife.

- **Clinical learning opportunities** means a range of learning experiences available in the health care setting or other experiential learning sites for a learner to gain required clinical skills which are: cognitive, affective and psychomotor skills (SANC, 2011).

- **Clinical placement** means the period spent by the learner in clinical and other experiential learning sites to ensure that the purpose of the programme is achieved.

- **Clinical Preceptor,** the word ‘preceptor’ comes from the noun ‘precept’ which means a general rule about how to behave or think. A clinical preceptor is

someone who shows people how to behave in a clinical situation, and they give support to students. They follow strict rules and etiquette; also act as a role model and a learning resource for students (Bruce et al., 2011). A preceptor is defined as a nurse who is experienced within a practice placement who acts as a role model and a resource for a student who is assigned to her for a specific period of time (Quinn, 2000).

- **Clinical supervision** is defined by SANC (2011) as assistance and support extended to the student by the professional nurse or midwife in a clinical facility to develop a competent, independent practitioner.

- **Clinical teaching** aims at producing a competent professional nurse capable of providing nursing care based on knowledge, decision making, practices skills and professional values (Bruce et al., 2009)
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- **Competency** is knowledge and skills and attitudes that enable an individual to perform a role or a task up to a defined level (Uys 2003). SANC defines competency as the ability of a practitioner to integrate the professional attributes including, but not limited to knowledge, skills, judgement, values and beliefs.

  According to Kombol, Kutner, Linda & Barger, (2012) The words **"mentor"** and **"preceptor"** sometimes are used interchangeably to describe individuals who provide expertise and experience and act as a role model. The term "clinical instructor" describes the person who provides educational preparation to the aspiring student nurse. All three do almost the same thing the only difference is the mentor and the preceptor are stationed in the clinical facilities working with the students at all times whereas the clinical instructors are based at the colleges, schools or universities they only go to clinical facilities during clinical accompaniments of students.

- **Registered Nurse** is a person registered with SANC as a nurse under Nursing Act, No 33 of 2005, as amended (Republic of South Africa 2005).

- **South African Nursing Council** is the body that sets and maintains 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 1994 and currently by the Nursing Act, No. 50 of 1978 as amended (Republic of South Africa 2005)

- **Student Nurse** is an individual who is undergoing training at a selected institution and who is studying full time towards the attainment of the Diploma in Nursing (General, Community, Psychiatry) and Midwifery, and whose name appears in the register or roll of nursing students in the SANC (Regulation No. R425 of February, 1987)

List of acronyms

Acronym	Full word
DUT	Durban University of Technology
ECP	Extended Curriculum Programme
HOD	Head of Department
KZN	KwaZulu Natal
MoU	Memorandum of Understanding
NQF	National Qualifications Framework
SANC	South African Nursing Council

CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND OF THE STUDY

The quality of the clinical learning environment is an important factor in determining the quality of nursing students' clinical experience. Clinical facilitators should ensure that students are placed in facilities that offer a positive learning environment, to support the achievement of clinical learning outcomes for the students (Balang, 2012).

Clinical teaching is the means by which student nurses learn to apply the theory of nursing in a clinical situation so that an integration of theoretical knowledge and practical skills in the clinical situation becomes an art and science of nursing. This also strengthens correlation of theory and practice (Mellish et al., 1998). Basic clinical learning is a requirement for all nursing students to meet their clinical learning outcomes and requirements. This entails placements of nursing students from their first year of training in different facilities, including hospitals, clinics, old age homes and crèches accredited by South African Nursing Council (SANC) for training purposes (SANC R 254, 2007). All the facilities where students are placed have to be accredited by SANC for training purposes as this is a requirement by SANC for the students to qualify as a professional nurse (Government Notice No. R.425, 1998).

The nursing students at the University of Technology that was studied are placed at local facilities in the province of KwaZulu-Natal (KZN), however, some facilities are far from the campus. According to SANC regulations, students are expected to work a minimum number of 1000 clinical hours per year and by the end of their 4 year training, all students should have minimum of 4000 hours of clinical training and they will not qualify until all the hours are covered. The University of Technology (UoT) in this study has been offering a nursing undergraduate Bachelor of Technology in Nursing Science (B Tech Nursing Science) course since 2010. The South African Nursing Council requirements are that clinical departments should

have policies, rules and regulations as well as clinical learning objectives for each learning area of the programme to guide students.

Clinical instructors also referred to as clinical facilitators at this UoT nursing programme, are tasked with the responsibility of clinical facilitation, supervision and assessment of learning in the clinical placements. It is important that clinical facilities where students are allocated are able to facilitate the achievement of the programme outcomes (Government Notice No. R.169, 1997). Andrews and Wallis (1999) cited by Andrews et al. (2006), states that for the clinical component to be effective there is a need for stronger communication links between mentors, lecturers, clinical facilitators, ward managers and all practitioners responsible for nursing education. Clinical accompaniment happens at a clinical setting which is defined as a learning environment in which a student acquires specific skills related to the needs of each patient (Carlson et al., 2003). However, there are challenges identified by the accompanists and students in some clinical facilities which limit the students in achieving their expected goals. In some hospitals or clinics the equipment is either outdated or there is no equipment at all to ensure that nursing students get the best training required. During clinical accompaniment the clinical facilitators are also expected to assist students improve their cognitive, psychomotor, affective skills as well as offer emotional support during learning in clinical placements. However, it has been noted that clinical accompaniment comes with many challenges. In a qualitative study by Chang and Pai (n.d.) in Taiwan, it has been found that clinical nursing facilitators have work-related stressors which included inadequate role occupancy, increasing work demands, deficient role preparedness, lowered role control, insufficient role support, and role bargain.

The aim of the present study was to assess the clinical training component of the undergraduate nursing programme at a University of Technology. The clinical training component at this UoT has not been reviewed since the start of the programme. It is envisaged that the findings from this study will inform an improved clinical facilitation programme, and aid in developing a clinical accompaniment tool in the future that could be easily used by both clinical instructors and lecturers during accompaniment of students when they are placed in different clinical facilities.

1.2 PROBLEM STATEMENT

The undergraduate nursing programme which had started in 2010 at this campus was in its fourth year when this study was undertaken. There are clinical instructors in this campus, who as one of their roles, have to accompany students to clinical training sites. The South African Nursing Council (SANC), also states that all nursing schools, colleges and universities must accompany students to the clinical training sites where they are placed.

Clinical accompaniment is defined by Bruce et al. (2011), as the conscious and purposeful guidance and support of students, based on their unique needs. Student accompaniment is important since the student needs to be guided, supervised as well as to be assisted with gaining self-esteem through academic and emotional support by an accompanist. Students also need to feel welcomed where they are allocated so that they work freely and are able to ask for assistance when necessary. This is the duty of a ward manager (Andrews et al., 2006). It is noted that in many nursing schools, lecturers feel that clinical accompaniment is only for the clinical instructors (Mntambo, 2009), whereas according to the SANC it is important that lecturers also accompany students to help them correlate theory and practice. According to Parish (2010), effective nursing clinical instructors are essential for maximizing nursing students' educational experiences and this can be done by working hand in hand with the lecturers.

One of the major problems at this UoT is that the facilities where nursing students are placed are far from each other and they are also far from the university, which makes it very difficult for the clinical instructors to carry out accompaniment appropriately. The time that is wasted on road travelling to see students could be converted to accompaniment time so that the clinical instructors could spend enough time with students. According to the SANC (1997), the clinical instructor should spend at least 30 minutes with each student per week. Therefore it is important that the placement areas are not too far from the campus. Students experience problems when they are allocated far from campus as they are unable to make use of the clinical skills laboratories for practice. Thus, this study aimed to identify challenges and to assess the facilitation of the clinical training component of an undergraduate

nursing programme at a University of Technology to ascertain the students and the lecturers' perceptions of the clinical training programme. Recommendations will then be made to improve the clinical training component.

1.3 SIGNIFICANCE OF THE STUDY

In nursing education, a student receives instruction both theoretically and clinically in the subjects prescribed in the curriculum by the South African Nursing Council (SANC R 254, 1997). This continues throughout the nursing training. Clinical instruction is effected through clinical teaching and learning, which is a requirement by the nursing regulatory body, the South African Nursing Council (SANC). For an undergraduate programme a student has to spend at least a minimum of 1000 hours per year in clinical placement to meet programme outcomes (SANC R 254, 1997). It is the responsibility of all nursing schools, colleges and universities to ensure that each student fulfils these requirements. For this to be effective, it has to be facilitated by lecturers and clinical instructors, through teaching and learning strategies to enable students to perform the clinical skill with knowledge and eventual competence. Therefore, clinical instructors are there to ensure that the students are competent in all skills, such as cognitive, affective as well as psychomotor skills. This may be beneficial to the programme by firstly reducing failure rates as well as dropouts, and secondly by producing competent practitioners. A positive relationship between lecturers and clinical instructors is of high importance and collaboration between them is important for student achievement, especially because the clinical facilitators assist students in correlating theory and practice. This statement is supported by McClure (2008).

At this UoT students are allocated far from the campus and often placements are not enough which makes it difficult to allocate and accompany them properly. Cragg et al. (2011), also state that it is quite a challenge to find appropriate clinical placements for the students. This therefore, leads to a theory-practice gap on what is taught in theory and what students actually encounter in clinical settings (Cragg et al., 2011). This is sometimes a problem since in most hospitals where students are allocated there is lack of certain specialized units, for instance in the orthopaedic and intensive care units. Locally, there are many hospitals and clinics with almost all the

specialised departments where students can gain clinical experience. Allocating students in the local facilities will have the following advantages: reduce high transport costs, have more control of students since they will be staying on campus. Students will be able to practise critical skills at the clinical skills laboratories at the campus after hours and maximise utilisation of clinical instructors where travelling time can be converted to accompaniment time and the instructors will have more time with the students. So far the students cannot be allocated in the local facilities due to these facilities citing capacity issues, and not being able to accommodate students from this university. Each training institution should have a clinical skills laboratory where psychomotor skills are simulated and practiced by students before they are allowed to practice in a live patient (De Young, 2009). Practice at the laboratories assists students to have confidence and relieve anxiety when students have to perform their skills in front of the patients. At this university there are laboratories used for students' simulation and practice. However since students are placed far from the university thus the use of the skills laboratories is inadequate.

According to Bruce et al. (2011), a clinical instructor is a professional nurse that the nursing school or clinical setting employs for the purpose of clinical teaching. Frequent open communication between the practice site and the nursing programme also assists in an effective clinical facilitation (Gubrud-Howe et al., 2012). Gubrud-Howe et al. (2012) stresses that clinical facilitators and staff in all placement facilities must articulate clear expectations for the clinical learning objectives. To ensure that clinical teaching is performed appropriately, hospitals should set up a specialized clinical teaching department for the daily teaching operations of clinical instructors and for coordinating and facilitating the clinical education of nurses (Bruce et al., 2011). This would also help the clinical instructors as well as students with privacy and sufficient time to discuss all the important work away from the patients.

The significance of the study was to identify challenges and to assess the facilitation of the clinical training component of an undergraduate nursing programme in order to recommend an improvement of the clinical facilitation component for the nursing students to gain enough knowledge and skills through clinical facilitation. Findings will inform an improved clinical facilitation programme, and could be used in developing a clinical accompaniment tool that may be used in the future by both

clinical instructors and lecturers during accompaniment of students when they are placed in different clinical facilities.

1.4 PURPOSE OF THE STUDY

This University of Technology (UoT) has been offering a nursing undergraduate B Tech Nursing Science course since 2010. No such study had been undertaken in assessing the clinical training component of an undergraduate nursing programme. Therefore this study aimed at assessing the clinical training component of the undergraduate nursing programme at the UoT, based on the perceptions of students, lecturers and experiences of the clinical instructors.

1.5 OBJECTIVES OF THE STUDY

- To assess the facilitation of the clinical training component by ascertaining the experiences of the clinical instructors during clinical accompaniment by using a focus group interview.
- To assess the facilitation of the clinical training component by ascertaining the perceptions of the lecturers by the use of a questionnaire.
- To assess the facilitation of the clinical training component by ascertaining the perception of the students by the use of a questionnaire.
- To describe the benefits of student accompaniment in the clinical facilities as perceived and experienced by the clinical instructors.

1.6 A MODEL GUIDING THE STUDY

A clinical placement education model, adapted from Andrews et al. (2006) was used to guide this study since it highlights the importance of collaboration between both departments involved in clinical training: a training institution as well as clinical placement facilities. Andrews et al. (2006) states that the role players for clinical facilitation during student clinical placement includes lecturers, clinical facilitators, mentors, ward managers as well as ward staff as proper support of nursing students for clinical facilitation to be effective. According to Andrews et al. (2006), clinical

educational models are influenced by the support that the students receive in the clinical setting. This model (Figures 1) highlights different educational environment practices.

1.7 CONCLUSION

This chapter presented a background of clinical facilitation at a University of Technology, experiences of clinical facilitators, lecturers and students. This study aimed at assessing clinical training component of the undergraduate programme. A model which was used to guide the study was also briefly mentioned. The next chapter will present reviewed literature on clinical facilitation as well as more detail on the model.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter presented an overview of clinical facilitation where it was noted that clinical facilitation is crucial since students are assisted to correlate theory and practice during clinical facilitation, which assist them in becoming competent registered nurses when they qualify (McClure, 2008). This chapter will present literature review which will clarify clinical facilitation in different countries as well as in South Africa. This will assist the researcher in noting challenges that have been identified globally as well as their solutions. The strategy used to find relevant literature included searching SUMMON, CINHAL and google scholar search engines. Key words used to search were clinical facilitation, clinical teaching, and perceptions of students in the clinical placement areas, student accompaniment and clinical supervision. Theses and dissertations were also viewed with the assistance of the librarian.

This chapter begins with the literature of clinical facilitation on studies done globally and in sub Saharan Africa including South Africa. This study addresses the impact of challenges on the quality of clinical education, clinical facilitation, and clinical learning environment in a UoT. A clinical placement education model by Andrews et al. (2006) was used as a guide in this study.

2.2 CLINICAL TRAINING GLOBALLY AND IN SOUTH AFRICA

2.2.1 Clinical teaching

Globally, clinical training is trying to close the theory - practice gap in nursing education and health care delivery continues to be major challenge in the nursing profession (Rahnavard et al., 2013). In the study that was done in Iran by Azad et al. (2011), it showed that clinical education is an important part of nursing education and that it forms more than half of the nursing curriculum.

Another study conducted in Cameroon by Eta et al. (2011), indicated that despite the importance of clinical teaching to the nursing profession, in multiple settings, Cameroon inclusive, student nurses were often taught by clinical nurse educators who had little or no prior formal teaching. They noted that there were no guidelines to assist clinical nurse educators on how to effectively teach and supervise student nurses. As a result, they faced challenges and could not adequately teach, guide, supervise and assess student nurses during clinical placements, thus potentially reducing their effectiveness as educators. One of the solutions to their challenges was employing a clinical nurse educator in particular and recommending that the health system in general should identify and address the challenges faced by clinical nurse educators (Eta et al., 2011).

Mabhuda et al. (2008) in a study done in Limpopo noted that clinical teaching is the means by which nursing students learn to apply the theory of nursing, facilitating integration of theoretical knowledge and practical skills in the clinical setting which becomes the art and science of nursing. According to Reilly and Oermann (1992) cited by Mabhuda et al. (2008), it is through experience in the clinical setting that student nurses acquire the knowledge, skills, and values essential to professional practice and become socialised into the nursing profession.

Moleki (2008) in a study conducted at the Free State found that nursing students were expected to achieve their clinical learning outcomes and as one of the requirements, they had to undergo basic clinical learning. This included clinical facilitation, supervision, assessments of learning in the clinical skills laboratory and clinical placements.

2.2.2 Clinical facilitation

In South Africa nursing is guided by the South African Nursing Council (SANC), a statutory body for nurses which governs all nursing institutions be it private or public. All nursing training institutions should be accredited by the SANC before they undertake any training. Clinical facilitation is also a requirement by SANC (SANC, R 425 1997).

Clinical facilitation is a process applied by a clinical instructor in a clinical setting and learning situation (Peter, 2008). Clinical teaching is specifically required when an institution, be it a hospital, clinic or community-based organization, receives students from a nursing education institution for the purpose of clinical learning. This is the duty performed by the staff in the clinical setting such as registered nurses, who have knowledge and experience as well as the clinical instructors who usually come to these institutions for accompaniment of students (Bruce et al., 2011). Clinical facilitation enables the students to learn from clinical environment through a process which makes it easy for them to reach their learning goals and be competent in the skills taught. The University of Technology in this study employed clinical instructors in a nursing programme to ensure quality of nursing care is provided by their students as well as to produce professional nurses who are proficient at the end of the course.

The clinical instructors at this university are tasked with the responsibility of clinical facilitation, supervision, assessments of learning in the clinical skills laboratory and clinical placements. At the University of Technology (UoT) being studied students have clinical skills laboratories where clinical facilitation, supervision and assessments take place. The clinical skills assessments are competency based where students practice a skill and are assessed. If the student is not yet competent on a certain skill, he/she is allowed to practice and be re-assessed until he/she is found competent. The South African Nursing Council (SANC) also recommends clinical placement of students as one of the requirements before completing the qualification (SANC regulations**,** 1997)**.** This calls for full support of students while they are placed, and clinical facilitators at this UoT are tasked with the role of accompanying the nursing students.

The process of accompaniment takes place in conjunction with the direct involvement and physical presence of a clinical instructor or nurse educator/lecturer, who supplements his/her work with guidelines and learning resources (Bruce et al., 2011). In this regard, at this campus the clinical department makes sure that each level of students achieves learning outcomes for each facility and each unit where they are allocated so that it is easy for the students to cope with the work by preparing themselves prior to presenting themselves in that unit. Clinical learning

objectives also assist the clinical staff to know the students expectations during their stay and according to their level of training (Mabhuda et al., 2005). In that case it should be made possible for the clinical instructors to be physically in the clinical areas in order to be able to teach students in the clinical facilities where they are placed. They will also assist the students in following and covering the learning outcomes given to them to assist with their learning (Bruce et al., 2011). According to Mntambo (2009) in a study done in Gauteng, clinical practice was found to be the core of nursing education during which the student is socialized into the nursing profession. During this period there is transfer of knowledge and skill from qualified nurses and other members of the multidisciplinary team to student nurses. White and Ewan (1984) cited by Mkhwanazi (2007) in a study conducted in Gauteng found that for facilitation to be successful one must ensure that there is supportive, nurturing, understanding and challenging environment for the nursing students.

Clinical facilitation assists students to be able to correlate theory learnt in class and practice by doing, and that helps because everything starts to make sense (Balang, 2013). For every student to be competent and become a safe practitioner they have to be competent in cognitive, affective as well as psychomotor skills so that they will be able to nurse a patient holistically (McLure and Black, 2013). Ard et al. (2008) cited by McLure and Black (2013), also support the statement by stating that a nursing faculty identifies the clinical learning environment as a holistic experience attending to cognitive, physical, and passion components with active involvement of all students, faculty, patients, and clinical staff. Therefore, clinical facilitation plays an important role in assisting a student in obtaining these skills. In order for clinical facilitation to be successful there should be good organization and communication between the university and the health professionals where students are allocated (Andrews et al., 2010). Andrews et al. (2010), further states that clinical placements can become a place of conflict whereby students experience high levels of stress and disillusionment if there is no support of both parties.

2.2.3 Student accompaniment

Closing the theory-practice gap is achieved by good student support when they are in clinical placements. In a study done in the University of Australia (Sanderson and Lea, 2012), the majority of students placed within health care facilities are placed in groups as the group model incorporates a facilitator who supervises the students who are placed across a number of wards. This grouping of students during accompaniment assisted the clinical facilitators in saving time and contacting more than one student at a time.

In some wards students are assigned a registered nurse (RN) who will be their mentor throughout a day. This approach is through a one-on-one supervision of students. Within the preceptorship model, students are supervised by an RN who is responsible for supporting them during their work integrated learning (WIL) experience. Sanderson and Lea (2012), further states that students supervised within the facilitator model were statistically more likely to be challenged to reflect, think, build on existing skills and knowledge and to problem-solve issues. Notably, all factors integral to registered nurse education. Overall, students considered the quality of support to be the most important facet of supervision (Walker et al., 2013). The goal of clinical education is to integrate theory and practice in a controlled environment to provide students with learning that has the appropriate skills, behaviours and attitudes that are necessary for entry into professional practice (Levy, 2009). Therefore for the student nurses to qualify as registered nurses at the end of their training, they also need to be competent in clinical skills.

2.2.4 Clinical placement areas

2.2.4.1 Purpose of placement

Clinical skills are primarily developed through clinical rotation within accredited health care facilities. The value of clinical placements to students is dependent upon the availability of space, the quality of the facilitation and the perceived burden to the organisation of providing places for students (Warmer, 2010). This UoT is still struggling to secure local clinical placements which poses a problem to students and

clinical facilitators. According to Balang (2012), clinical practicum is a vital component of nursing education. It provides students with a direct, real experience of the nursing profession as they participate in routine nursing activities of the ward and working together with the staff (Chapman and Orb, 2000). This statement is supported by Shin (2000) by alluding to the fact that clinical placement provides students with an opportunity to be actively involved in patient care. More importantly, clinical practicum provides the opportunity for students to strengthen their clinical skills. Students are responsible for integrating theory into practice and to gain real nursing experiences while being facilitated by their clinical supervisors (Chan, 2002).

In clinical-education settings, students practice and develop psychomotor skills and incorporate the attitudes, values and beliefs of professional practice (Lauber et al., 2003). Therefore, quality clinical instruction is important to facilitate student learning of cognitive, psychomotor, and affective domains fundamental to clinical practice (Lauber et al., 2003). Effective clinical nursing instructors are essential for maximizing a nursing student's educational experience (Parish, 2010). Stevens (2004) stated that clinical instruction is a set of planned experiences designed to help students acquire skills, attitudes, and knowledge by participating in the work setting. Clinical instruction also involves teaching attitudes by role modelling as well as helping students relate classroom teaching to clinical practice. According to Parish (2010), supporting learning in practice includes teachers helping students develop and practice skills and knowledge.

2.2.4.2 Factors influencing placements

One of the most integral components in the nursing education programme is clinical placement. According to Elliot (2002), clinical placements provide students with the opportunity to experience nursing in the real world and enables students to put theory into practice. Chan (2003) stated that nursing students perceived the clinical setting as the most influential context for acquiring knowledge and nursing skills. Barnett et al. (2011) found that clinical placement fosters in students the application of knowledge skills and attitudes to clinical field situations. Hence, it is vital that valuable clinical time should be utilized effectively and productively. Mellish et al. (1998) stressed that the benefits of practicing in an appropriate clinical learning

environment at the proper time is that theory and practice can complement each other. Beukes et al. (2010) stated in their study that in the clinical field, community nurses and undergraduate students were representative of the different races and language and ethnic groups in the South African population, with each group espousing different value systems. Students and community nurses reported that due to these differences, value conflicts were experienced during clinical accompaniment and that this had negative effects on clinical learning in community nursing science. They then explored and described the experiences of students with regard to value-sensitive clinical accompaniment in the community nursing environment where a descriptive and contextual design was used. Guidelines for value-sensitive clinical accompaniment for undergraduate students in the community nursing environment were developed (Beukes et al., 2010). The following values for which guidelines needed to be developed were identified: respect during clinical accompaniment, value-sensitive communication and sensitivity to the quality of clinical accompaniment.

2.2.4.3 Challenges experienced in placements

An effective clinical practicum should focus on the students' needs, abilities, interests and learning styles, to provide adequate exposure and achieve learning objectives in the clinical settings (Elliot, 2002). Despite being designed to provide a positive exposure to the students, they reported often hearing that students experienced problems and difficulties during their clinical placement (Nasrin et al., 2012). As nursing education programmes are significantly increasing their undergraduate enrolment in order to ease the ongoing nursing shortage, nursing educators face the challenge of providing quality clinical learning experiences for the growing number of students. Clinical practice environments are complex and dynamic, and bring with them experiences for both educators and students such as: when you find a student doing something wrong to a patient during a procedure, it is important to correct him/her there and there (teachable moments), which sometimes causes an embarrassment to a student and resulting in the patient not trusting that particular student any more (Stevens, 2004).

Due to a shortage of clinical placement sites and advancements in technology, nursing students are increasingly learning clinical judgement and decision making in the simulated clinical experience. Evaluation of the clinical supervision and professional development of student nurses clarified that clinical supervision strongly influences the student nurses' development of professional identity, enhancing decision-making ability and personal growth (Severinsson and Sand, 2010). However, a qualitative study by Chang and Pai (n.d.) in Taiwan found that clinical nursing instructors' work-related stressors included inadequate role occupancy, increasing work demands, deficient role preparedness, lowered role control, insufficient role support, and role bargain. When a clinical instructor with lowered role control experiences more stressors, the situation of role stress deteriorates. Role support and role bargain are the buffers of work-related stress to adapt clinical instructors for the rapidly changing educational and medical environment. Adequate role credibility for role occupancy was a necessary strategy for reducing clinical instructors' work-related strain (Chang and Pai, n.d.). In this UoT it was noted that there was lack of support, deficient role preparedness and increasing work demand which might affect the way clinical instructors function if these are not corrected.

Collaboration of both the university and clinical facilities will improve student support. This will relieve ward managers of not knowing who to communicate with, when they need to communicate about students. Charnelia (2007) in her study conducted in Capella University in New York also indicated a partnership between universities and hospitals. The preceptors are paid by the universities as they are relieving the clinical facilitators and they are always with the students, supporting them throughout their stay. Andrew et al. (2006) also support the collaboration of the training institutions and clinical placement facilities where there is understanding between the two, regarding students and in improving student support.

Murati et al. (2005) in a study done in the University of Venda states that the comprehensive nature of nurse training needs the involvement of almost all health team personnel, including unit managers for a student to gain practical experience and learn to correlate theory and practice. The overall aim of their study was to explore and describe the experiences of unit managers regarding teaching of student nurses in the clinical area and to develop recommendations that will enhance clinical

teaching. This was to assist in producing competent nurse practitioners who will render quality care to patients. The following recommendations were made: opening a two-way communication with unit managers, involvement of unit managers in the activities that take place at the college such as courses, seminars and workshops on clinical teaching. Furthermore, Murati et al. (2005) states that learning contracts should be developed for the students and issues of clinical learning should be addressed and unit managers should be included in both summative and formative evaluations of students. The clinical area is an important learning environment for undergraduate nursing students. Unfortunately, it can also be a source of significant stress and anxiety for students and there are a number of reasons for this, such as lack of resources and bad attitude by staff members. Much can be done to help alleviate this stress and create a positive learning environment for students (Elliott, 2002).

There are conditions for accreditation of any nursing education institution to offer any nursing course; one of the conditions is that the nursing education institution has access to clinical facilities which are appropriate and relevant for the achievement of the outcomes of the programme (SANC, 2011). This statement is supported by Peter (2008) that it is the duty of the clinical facilitator to try and organize student learning in the clinical field where students will be allocated, and also to develop effective strategies for teaching and learning through practice. The UoT being studied has managed to secure relevant and appropriate clinical placements for their student nurses. One of the challenges is that some facilities are far and have limited special units for the students to learn, therefore, time is wasted travelling on the road instead of proper student accompaniment where learning would take place. It is crucial that students demonstrate correlation of theory with practice during clinical placements and this is ensured by clinical accompaniment by the clinical facilitators (Moleki, 2008). Supporting students to learn in clinical settings is cited in a study done in Durban as an important function for both educators and practitioners (Pillay and Mtshali 2008), yet there is little consensus in the literature as to what constitutes appropriate support of clinical learning (Pillay and Mtshali, 2008). Mabhuda et al. (2008), states that the environment for student nurses depends on the availability of placement support systems, such as supervision, mentorship, preceptorship and relationships between the faculty, student nurses and clinical staff. Hence, clinical

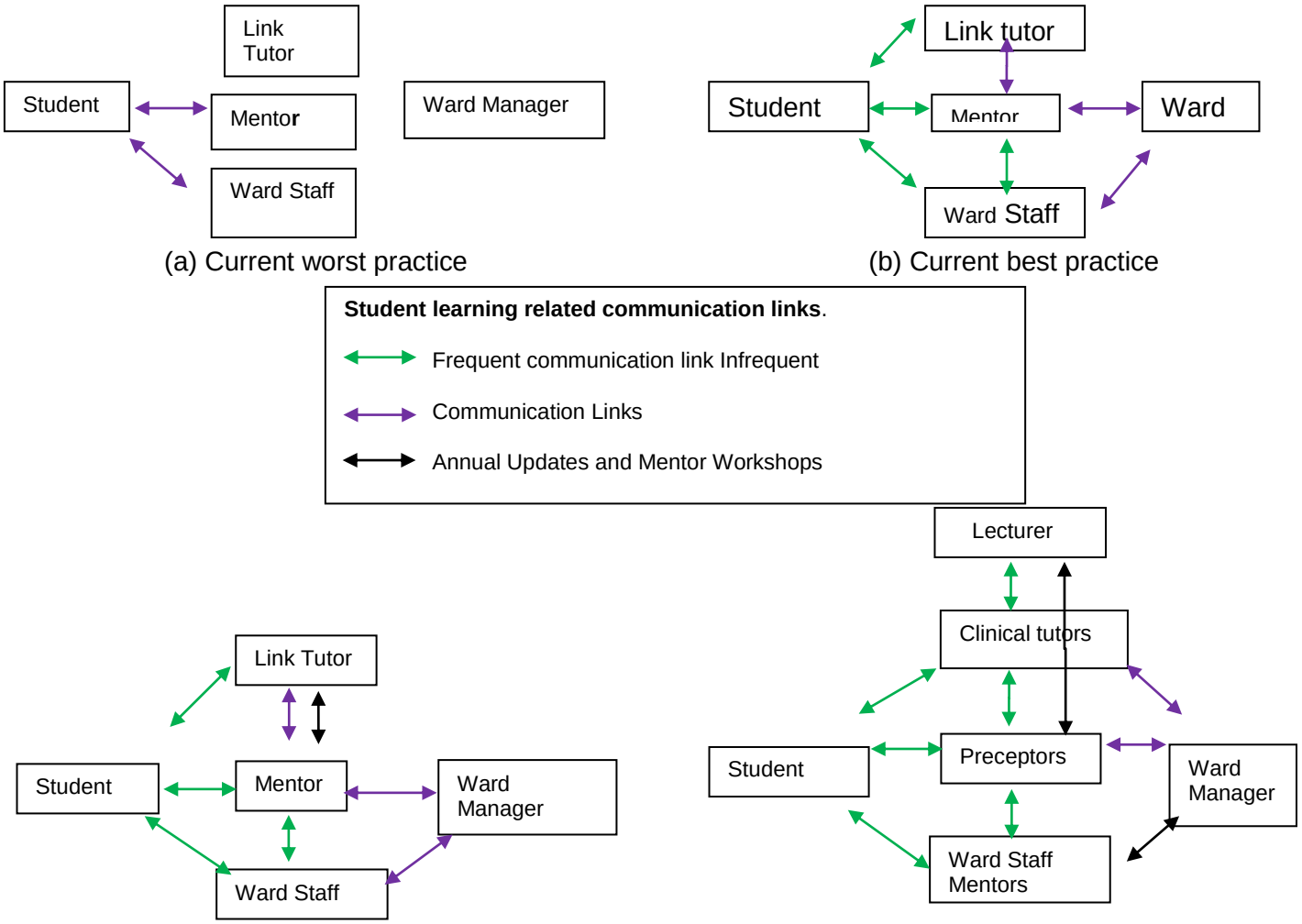
accompaniment is meant to ensure that graduates in their clinical settings display the goals of measurable clinical competencies, and according to Andrews et al. (2006), this cannot be done by clinical facilitators alone but there are other team players who will make sure students have enough clinical support, and those are: lecturers, mentors, ward managers, ward staff and students. Lekhuleni et al. (2004) also support this statement by saying that nurse educators need to ensure that clinical learning outcomes are discussed with the unit supervisors and the student nurses prior to placement for effective clinical facilitation. This collaboration will reduce challenges faced by staff in clinical facilities, by clinical facilitators and students during clinical placement. Andrews et al. (2006) states that all key players should have clear roles and responsibilities defined at both academic and service setting.
Role players for clinical facilitation during student clinical placement include lecturers, clinical facilitators, mentors, ward managers as well as ward staff as proper support of nursing students is required for clinical facilitation to be effective (Andrews et al., 2006).

According to the literature the countries had similar goals regarding clinical facilitation. Assisting students in correlation of theory and practice by clinical facilitation and education during clinical accompaniment was one of the important aspects cited. The other point was the importance of employing mentors who will be based at the clinical facilities to assist students with all their needs during placement. It was also cited that students felt that clinical placements provided them with the opportunity to experience nursing in the real world and enables them to put theory into practice. It appeared that improvement of collaboration between both training facilities and clinical placement facilities was also common and crucial.

2.3 MODEL GUIDING THE STUDY

According to Andrews et al. (2006), clinical educational models are influenced by the support that the students receive in the clinical setting. To guide this study a clinical placement education model was used. This model was adapted from Andrews et al. (2006) and it was chosen because it covers both departments: a training institution as well as clinical placement facilities. The model focuses more on the relationship between the lecturers, clinical instructors, ward managers, mentors and staff, with

the students. The Andrews et al. (2006) model (Figures 1) highlights different educational environment practices which are: current 'worst practice', current 'best practice', recommended minimum 'best practice', recommended 'best practice'. The last practice, which is the recommended 'best practice' was used in this study.



(a) Current worst practice (b) Current best practice

(c) Minimum practice (d) Recommended 'best practice'

Figure 1: A clinical placement education model adapted from Andrews et al. (2006)

This clinical placement education model (Figure 1) illustrates four types of sections which highlights different educational environment practices which are: 1 (a) current 'worst practice', 1 (b) current 'best practice', 1 (c) recommended minimum 'best practice', 1 (d) recommended 'best practice'. The last practice, which is the recommended 'best practice' model of clinical placement and educational collaboration, incorporating staff from clinical facilities and a training institution was

used in this study. This practice was chosen in order to assist in recommending an improved clinical facilitation since it incorporates all people who should be involved in it.

2.3.1 The four sections of the model

2.3.1.1 Current ‘worst practice’

Figure 1 (a) explains a practice whereby a student receives support from the ward staff and minimal support from the mentor. There is no student support from the ward manager, clinical facilitators or lecturers which makes this learning environment frustrating for the students to learn. Ward staff have no one from the training institution to communicate with if there are any problems regarding students, or if they want to know about clinical objectives.

2.3.1.2 Current ‘best practice’

Figure 1 (b) shows a positive learning support where a student receives support from mentors, ward staff and frequent visits from link tutor (lecturer) that also provide clinical teaching as required by South African Nursing Council (SANC). In this figure a student feels safe, ward staff also can discuss a student’s progress with the lecturer and they can also have workshops regarding clinical teaching and discuss any issues. Even the ward manager is involved in this stage which makes the students feel welcome. This is rated as ‘best practice’ because it has personnel from both clinical facilities and a training institution involved in the programme.

2.3.1.3 Recommended minimum ‘best practice’

Figure 1 (c) shows less communication between the lecturer and the mentor but the student still receives support from the ward manager, mentor, ward staff as well as the lecturer. Having all this support the students feels welcome in the ward and they will be able to learn.

2.3.1.4 Recommended ‘best practice’

Figure 1 (d) is the best ideal practice model which will be used to guide this study. This last model incorporates staff from the clinical facilities (ward manager, mentors and ward staff) and staff from the training institution (lecturers and clinical facilitators). In this way students receive maximum educational support and there is a good relationship between the clinical facilities and training institutions.

2.3.2 Roles of all the team players in the Recommended ‘best practice’ model

2.3.2.1 Mentor

Watson cited by Lekhuleni et al, (2004) explains a mentor as a concept derived from a Greek mythology, where Mentor was a trusted friend of Odysseus and his sons tutor, Telemachus. The relationship between Mentor and Telemachus was described as nurturing, educative and protective, as Mentor ensured that Telemachus developed personally, socially and professionally. Therefore, a mentor has a role of supporting students personally, socially and professionally as well as facilitates their learning experience in the clinical area since they are experienced (Andrews et al., 2006). According to Bruce et al. (2011), a mentor also serves as a professional role model and assists the student in understanding the culture of the organization. In other studies a term ‘mentor’ is used interchangeably with the term ‘preceptor’ (Peter, 2008). However, Fox et al. (1992) cited by Bruce et al. (2011) distinguish the difference between a mentor and a preceptor (Table 1).

Table 1: Comparison of mentor and preceptor (Fox et al., 1992)

Mentor	Preceptor
Relationship is active, ongoing and intensely personal.	Relationship is more active, may be a formal orientation process.
One member guides and counsels, both members share personal and professional goals.	One member coaches, teachers and supervises, the other members learns.
Relationship may last for years, it terminates by mutual agreement	Relationship may end when orientation is complete, or may develop into a mentoring relationship.

Some of the characteristics of a mentor as described by Bruce et al. (2011) are as follows:

The mentor should:

- be enthusiastic about the subject and about life
- be knowledgeable in the specific discipline and wise
- give advice and guidance
- have multi-faceted experience
- have high level of competence
- be a role models leadership with patience
- instill vision, encourages and inspires by sharing a dream
- have superior problem-solving skills
- promote independent decision making

A mentor is defined by Quinn (2000) cited by Lekhuleni (2004) as a qualified and an experienced member of the clinical environment and who enters into a formal arrangement to provide educational and personal support to a student throughout the placement period. The government has called for universities to increase the number of nursing students due to staff shortage in the service. Clinical accompaniment with a large number of students and clinical placements which are a challenge in many training institutions, therefore mentors would play an important role in assisting with student support (Lekhuleni et al. 2004). Andrew et al. (2006), encourage collaboration of both clinical facilities staff and staff from the training institutions to make things easier for everyone including the mentors. Therefore,

when students work alongside experienced practitioners, they will learn from experts in a safe, supportive and educationally adjusted environment in preparation for the uptake of their personal role (Andrews et al., 2006).

Mentors follow certain steps in order to make their mentoring role work well and to ensure they facilitate a successful mentoring programme. Figure 2, adapted from Bruce et al. (2011) shows steps in the mentoring circle.

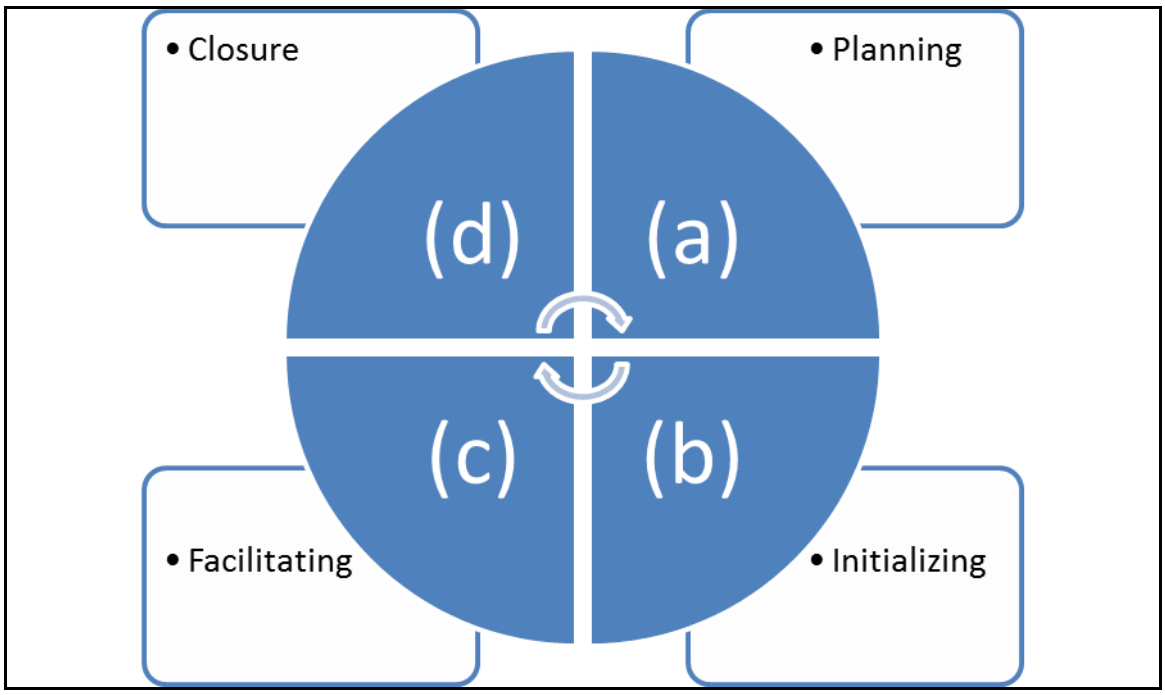


Figure 2: Mentoring circle consisting of four steps: planning, initializing, facilitating and closure (Bruce et al., 2011)

The four phases of the mentoring circle include the following:

(a) **Planning phase**: when a mentor starts preparing for the relationship with the students which will assist in monitoring students. This stage helps with building trust between the mentor and the student.

(b**) Initializing phase**: where the mentor meets the students for the first time and they discuss the goals to be achieved during their stay. During this meeting they get to know each other and trust is also developed. Expectations are clarified, including responsibilities as well as accountability. Lastly the ground rules are discussed. All this can be done on the orientation day.

(c) **Facilitating phase**: where the mentor and the students start to bond and the mentor starts to reflect and give constructive feedback about the student's experience and guidance is provided. Moving from planning to action is what is expected in this step and students are expected to be able to solve problems guided by the mentor.

(d) **Closure**: the last phase of the mentoring circle which poses feelings like anxiety, sadness, joy, relief and disappointment because of termination of process. Before ending this phase, the mentor ensures that students have gained the decision making skills and they can now correlate theory with practice.

This mentoring circle should be used in all the training facilities where students are allocated in order to produce competent professional nurses. Currently not all clinical placement facilities have mentors for student support. It is crucial that mentors should be trained before they are placed in the facilities for effective supervisory systems (Saarikoski et al., 2007).

2.3.2.2 Ward manager

Ward manager according to Falender and Shafraske (2003) cited by Moleki (2008) is a ward supervisor who plays an important role in the students' stay during clinical placement by involving education and training aimed at developing a student into a science formed practitioner. In the South African Nursing Council Government Notice No. R. 169, 1997 clinical supervision is defined as the assistance and support extended to the learner by the professional nurse at the clinical learning sites with the aim of developing a competent and independent practitioner.

Ward manager is another key team player in the facilitation. Cassimjee and Bhengu (2006) cited by Peter (2008), stated that students believe that the ward sister is ideal for the role of clinical instruction since she is always there in the ward and has more contact time with them. The findings revealed that clinical supervision contributes positively to the academic, professional and personal development of students (Peter, 2008). This statement is supported by Lekhuleni et al. (2004), when saying

that the role of a supervisor is to facilitate growth of nursing students, both educationally and personally. Therefore, supervision is one of the things that boost self-esteem on nursing students having an experienced senior person with them. Findings in a study done by Pillay and Mtshali (2008) in Durban, states that staff is a key factor in influencing the learning environment of student nurses during the clinical practice, the role of the unit manager being particularly important. The unit manager must orientate students on their first day of placement, plan a teaching programme based on their learning outcomes and allocate them according to their level of training (Moleki, 2008).

Andrews et al. (2006) state that unit managers play an important role in influencing staff attitudes and actions towards nursing students during their clinical experience, and concurrently ensuring the quality of teaching needed by students. Therefore, this will establish a facilitative, conducive learning environment for the nursing students. Ward managers should encourage, motivate and appreciate students by showing interest in the student progress shown during their stay and in the necessary record keeping such as report writing (Moleki, 2008).

Bruce et al. (2011) states that the ward manager should be familiar with the clinical learning outcomes of each student allocated in his/her unit. When a student is observed to be competent in a certain skill, that student may be requested to demonstrate to other students, which will boost the students' self-esteem and encourage peer group teaching.

2.3.2.3 Ward staff

The main function of every nurse is to ensure that all patients under their care receive the best possible health care. In order to maintain this, nurses must ensure that those carrying out patient care which usually are the students, are capable of providing the necessary care (Bruce et al., 2011). If the students are unable to do so it is the duty of the ward staff, especially the registered nurses, to teach, mentor and supervise them (Bruce et al., 2011). Andrews et al. (2006) supports this statement by saying that, besides the unit manager and a mentor there are other professional nurses who work hand in hand with the students for support and they form part of the

team (Andrews et al., 2006). A Clinical staff is referred to as a registered nurse who is an independent practitioner authorized to practice, and capable of practicing nursing in his/her own right, by virtue of registration in terms of section 16 (SANC regulations, 1997). In a study by Pillay and Mtshali, (2008), one of the concerns by students was, “although there was support for clinical supervision by the nursing staff, the main problem was insufficient time for clinical supervision since they were always busy”. Thus clinical supervision was viewed as time consuming for the ward staff (Pillay and Mtshali, 2008). Therefore, in the clinical setting the unit professional nurse’s main function is to ensure that the patient or client in his/her care receives the best possible healthcare. In order to achieve such quality care, the unit professional nurse must ensure that those who are carrying out the care, of which in this case are the nursing students, are capable of providing it. If students are unable to do so, the professional nurse has a moral duty to teach, mentor and supervise them (Bruce et al., 2011).

2.3.2.4 The patient/client

All patients have rights which were drawn up by the Department of Health for their protection and all health practitioners should respect and follow these rights throughout the patient’s stay in a health care facility. The purpose and expected outcome of the patients’ rights charter and complaints procedure is to deal effectively with complaints and rectify service delivery problems and so improve the quality of care, raise awareness of rights and responsibilities, raise expectations and empowerment of users, change attitudes by strengthening the relationship between providers and users, improve the use of services and develop a mechanism for enforcing and measuring the quality of health services (Department of Health, 2008).

2.3.4.4.1 Patients’ Rights

Every patient has a right to:

- Healthy and safe environment
- Participation in decision-making
- Access to health care
- Knowledge of one’s health
- Insurance/medical aid scheme

- Choice of health services
- Treated by a named health care provider
- Confidentiality and privacy
- Informed consent
- Refusal of treatment
- A second opinion
- Continuity of care
- Complaints about health services

The patient, as a human being whose rights and dignity must be respected at all times, need to be asked for consent whenever he/she is going to be used for teaching purposes. An explanation of what is going to be done and why it needs to be done must be discussed with the patient, as the patient is not an object but has a right to give or refuse consent. All students must be encouraged and guided in practicing and respecting patients' rights on all patients. An appropriate patient must be chosen so that the student can benefit from the learning experience. It is important that a suitable time be planned for the patient/client to prevent any inconvenience. The privacy and confidentiality of the patient/client must be maintained at all times (Peter, 2008).

Patients believe in people giving them care and they think they are all knowledgeable thus, it is important that students are supported, guided and encouraged in order for them to be competent in what they are doing. This statement is supported by Mkhwanazi (2007) in her study titled, "The role of the nurse educator in supporting pupil nurses" which was carried out in KwaZulu-Natal, where she stated that student nurses are educated and trained so that they are prepared to provide safe nursing care in the clinical area. This is achieved by proper support in the clinical area which can be done in the form of facilitation of learning, supervision and counselling. Therefore, competent students will ensure patient safety at all times.

2.3.2.4.2 Batho Pele Principles

Batho Pele principles, which mean people first were developed to improve the public service delivery and to strengthen the quality of nursing. These principles are ongoing and dynamic process (KwaZulu Natal Department of Health, 2001). Students are taught the importance of adhering to these principles as they improve quality in nursing. The following are the Batho Pele principles with the explanations by the Department of Public Service and Administration (1997).

Consultation: This means that everyone should know about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered.

Service Standards: All citizens should be told what level and quality of public services they will receive so that they are aware of what to expect. This refers to the service standards that pertain to the functions of the ward. Information that should be displayed for patients and their families includes rosters for nursing staff , schedules for serving meals, times for doctors rounds and visiting hours.

Access: All citizens should have equal access to the services to which they are entitled to. This also refers to availability of resources and respect for human dignity.

Courtesy: Citizens should be treated with courtesy and consideration. Courtesy is displayed in many ways like practicing good manners and respect towards all citizens.

Information: Citizens should be given full, accurate information about the public services they are entitled to receive. All questions and queries addressed correctly with respect.

Openness and transparency: Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge. This way it would be easy for them to channel their queries to the correct people.

Redress: If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when the complaints are made, citizens should receive a sympathetic, positive response. This principle requires an active approach to handling complaints.

Value for Money: Public services should be provided economically and efficiently in order to give citizens the best possible value for money. This means that budgets should be planned carefully and the resources should to be properly controlled.

Encouraging Innovation and Rewarding Excellence: Innovation can be new ways of providing better service, cutting costs, improving conditions, streamlining and generally making changes which tie in with the spirit of Batho Pele. It is also about rewarding the staff who “go the extra mile” in making it all happen.

Customer Impact: Impact means looking at the benefits provided for the customers both internal and external. This principle also shows how the overall service delivery and customer satisfaction has improved. It is also about making sure that all customers are aware of and exercising their rights in terms of the Batho Pele principles.

Leadership and Strategic Direction: Good leadership is one of the most critical ingredients for successful organisations. Organisations who do well in serving their customers can demonstrate that they have leaders who lead by example, who set the vision, and ensure that the strategy for achieving the vision is owned by all and properly deployed throughout the organisation. They take an active role in the organisation's success.

It is important that students are aware of patients’ rights and are able to apply them with the Batho Pele principles for an improved public service as well as quality nursing care.

2.3.2.5 Clinical facilitator

Ferguson (1996) cited by Peter (2008) mentioned that clinical facilitators sometimes have a sense of belonging when they are in the clinical placements accompanying students and it is also noted that they may not feel as part of the team in certain departments because of some of the negative staff attitudes towards them. With the use of the recommended 'best practice' clinical placement education model adapted from Andrews et al. (2006), where there is collaboration between training institutions and clinical placements, there will be good understanding between the clinical facilitators and staff in the clinical facilities. The clinical facilitators may not be required to meet the students in person throughout the training as a result of distance between the campus and the facilities. They can see the students once a week as expected and mostly depend on preceptors, mentors, managers and ward staff to support the students to meet the required clinical competencies as guided by the program outcomes (Andrews et al., 2006).

Bruce et al. (2011) defines a clinical instructor as a professional nurse employed by the clinical setting for the purpose of clinical teaching. With a large number of students allocated in the facilities and few clinical instructors, students end up being seen in groups. Bruce et al. (2011), supports this statement and states that clinical instructors have:

- several students at the same level of training.
- an opportunity get to know individual students and their learning needs.
- opportunity to assess students and be able to give simultaneous feedback.
- opportunity to work closely with each student each time.
- opportunity to establish good interpersonal relationships and mutual trust with professional nurses.

2.3.2.6 Link tutor/lecturer

A study by Peter (2008) in Gauteng found that, with the new clinical teaching changes, it is imperative that even the lecturers who teach theory should also accompany students to bridge the theory practice gap. Unfortunately, this is still a

problem with some of the lecturers at this UoT as they feel that student accompaniment is the duty of the clinical facilitators only.

According to Quinn (2000) cited by Mogale (2011), the link teacher communicates with the unit managers and students, and therefore develops qualified staff and help in problem-solving and maintenance of a positive learning environment for students support. Qualified staff can include the supervisors/unit managers, mentors and preceptors.

Andrews et al. (2006) state that a link tutor plays an important role of ensuring the provision of appropriate learning experiences for students to meet specified learning outcomes. A link tutor works hand in hand with all the other team members in student support to ensure that nursing students' placements achieve the appropriate experiences and outcomes and that intended goals and objectives are met. A nurse educator must see their role extending beyond the classroom and clinical laboratory into the area of clinical practice (Bruce et al., 2011). Therefore lecturers should also participate in in-service training in the clinical facilities, and attend workshops on best clinical practices in order to be updated with new information (Mabhuda et al., 2008).

The study by Lekhuleni et al. (2004) also indicated that problems are experienced by students in terms of accompaniment where there was role confusion in terms of their accompaniment where they do not know what to expect during accompaniment. Most nurse educators do not perceive accompaniment as their role, instead they indicated that the unit managers and registered nurses should accompany students as they are in the clinical field.

2.3.2.7 Nursing students

In a study conducted by Pillay and Mtshali (2008), students reported negative experiences in the clinical environment. These negative experiences include the following:

- Expectations of students not being met, as the staff are not aware of the students' learning outcomes.

- Frustration experienced during daily practice due to poor integration of theory and practice.
- Lack of tutorial support and guidance by lecturers.
- Lack of interpersonal relationships between the ward sister and students.

Inadequate accompaniment in the clinical settings would hinder students' professional and cognitive growth (Lekhuleni et al., 2004). Nursing students also have a responsibility towards their learning. Therefore, it is important that the Andrews et al., model (figure 1(d)) be used so as to ensure that both training institutions and clinical placements work together for student support as students are vulnerable and need guidance.

Bruce et al. (2011) explains that the Maslow's hierarchy of needs theory (1970) is relevant for meeting the students' needs as the Maslow's theory states that everybody has needs and students also have needs (Figure 3). It has been observed that students are vulnerable as they have fear of the unknown from the beginning of the course and no one usually pays attention to their needs. The Maslow's hierarchy of needs is usually used towards patients but it can also work well on student needs (Bruce et al., 2011). The Maslow's hierarchy of needs includes:

- Physiological/ basic needs,
- Safety/security
- Belongingness and love needs
- Esteem needs
- Self-actualization needs

Figure 3: The Maslow's hierarchy of needs theory (1970)

Maslow suggested that human beings have needs which he positioned in a hierarchy ranging from the basic needs for survival to the need for self-actualization. All students must meet their basic needs first at least partly, before striving towards satisfying the higher needs. At the beginning students are not certain whether they are in the right profession, they need lots of support and as the years go by and they are at their third to fourth year of study they gain self-esteem and are independent. Therefore the main aim of clinical teaching is to guide the student towards these goals where the student has gained self-esteem and independence (Bruce et al., 2011).

2.4 THE LEARNING ENVIRONMENT

Researchers such as Peter (2008), feel that there is a need for preparing students for clinical placement. This can be done by relevant and sufficient theoretical teaching and simulation at the clinical skills laboratory. The clinical environment must be conducive enough to deliver quality nursing care, promote competency, provide opportunity for facilitation of learning, provide space and enough equipment (Moleki, 2008). The clinical environment is risky and dynamic, so students are commonly supported and supervised by a clinical teacher/educator. Clinical placements enable students to meaningfully transfer learning from theory to practice. This is where

students receive maximum benefit. Academic hospitals or training hospitals commonly allocate the teaching of specialized skills to a designated person such as a professional nurse in a unit (Bruce et al., 2011). Quality clinical instruction is important to facilitate student learning of cognitive, psychomotor, and affective domains fundamental to clinical practice. Bruce et al. (2011), stated that nursing is a practice-based discipline and clinical practice is considered to be an integral part of nursing education. The pivotal role that the clinical instructors play in the socialization, teaching and assessing of student nurses, is vital in helping students to integrate theory with practice (Nurs, 2008). It is important that in all the clinical placements in each unit there is a nurse preceptor allocated specifically for student accompaniment with minimal patient care responsibilities and administration of the unit in order to perform this duty properly (Cele et al., 2002). This will also help nursing students from the UoT in this study as their clinical facilitators are not in clinical placements every day since the facilities are far and many.

A qualitative study was performed in one of the public hospitals in Gauteng (Mtambo, 2009), where the participants were student nurses and clinical accompanists. The findings revealed that participants regarded relationships and communication as important for clinical accompanists and students during clinical accompaniment. Both student nurses and unit managers expected clinical facilitators to accompany students in clinical settings and some hospital staff members did not perceive clinical accompaniment to be their task, which made it difficult for the students to adjust easily in the clinical placements. Student nurses also felt that facilitators were not performing their duties as they appeared to be “lazy and old”. The following were some of the recommendations made by the participants:

- The hospital needed to appoint additional staff in order to improve the quality of patient care.
- The roles of the student nurses and the reasons for which the SANC required them to be placed in hospitals for clinical accompaniment need to be defined by the SANC so that permanent staff of the hospital would know why these students were being placed in clinical settings.
- The nurse administrators (from the hospital) and nurse educators (from the college) need to foster a good relationship.

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

According to the SANC rules and regulations, a clinical facilitator should spend a minimum of 30 minutes with each student during clinical practice. This is a challenge since there is a large number of students and few clinical facilitators. The other challenge is that some facilities are far and student time is spent travelling to and from the clinical facilities. It is highlighted in a study by Peter (2008), that lecturers also need to do accompaniment to close the theory-practice gap as it was noted that that there is a discrepancy between classroom theory and learning that takes place in the clinical area. This statement is supported by Lekhuleni et al. (2004) who indicated that nurse educators found that methods of patient care management taught to students were not introduced into the clinical setting. Therefore it is crucial that the lecturers also do accompaniment to integrate theory and practice. This will also increase the number of accompanists and students will receive more support.

2.5 CLINICAL ACCOMPANIMENT

The South African Nursing Council states that all learners shall, throughout the training programme, receive integrated education and training to achieve both theoretical and clinical outcomes. To achieve these, students at this university in the present study are given lectures on theoretical knowledge and clinical facilitators assist them with clinical practice in the simulation laboratories. They are then allocated in different clinical facilities and are accompanied weekly for support and to achieve their learning outcomes. Different terminology is used to describe clinical accompaniment by different researchers, in some studies clinical accompaniment is located within the spectrum of mentorship, preceptorship and coaching (Moleki, 2008). Bruce et al. (2011) defines clinical accompaniment as a process whereby there is direct involvement and physical presence of a nurse educator who supplements her work with guidelines and learning resources to close the theory-practice gap.

Lekhuleni et al. (2004) states that effective accompaniment in a hospital-based nurse training programme, requires nurse educators to provide support and encouragement during accompaniment in clinical settings. Lecturers should have time to develop and maintain their clinical skills and be involved in clinical teaching for at least one day per week. Quinn (2000) cited by Lekhuleni et al. (2004) further state that nurse educators, should also ensure that learning objectives are met by liaising with unit supervisors, clinical facilitators and the student nurses. This statement is supported by Peter (2008) when she stated that a lecturer who also does clinical accompaniment is believed to be creating and developing a role that attempts to bridge theory-practice gap between nurse education and practice.

Students' feelings about clinical accompaniment are explained by Peter (2008). There is importance of a staff-student relationship during clinical learning. Students also feel that there is no feedback at the end of their stay in the clinical facilities by mentors and RN's. De Young (2009), states that students in the clinical area expect to be informed if they meet the expected objectives and that they are safe practitioners. Therefore, it is important that students are given positive feedback so they are aware of their strengths and weaknesses.

It was noted that in this UoT under investigation there is lack of collaboration between the two facilities which is the university and the clinical placement areas and this causes problems between the two facilities. Lecturers also do not take student accompaniment as part of their duty and most of them do not do it at all. It is therefore not easy to break the theory-practice gap which is important in the student support.

2.6 CONCLUSION

In this chapter an in-depth literature was presented about clinical facilitation guided by a clinical placement education model adapted from Andrews et al. (2006). Based on the literature review, it is clear that a gap exists between clinical facilities and training institutions which make things difficult for the students as they do not receive enough support in their learning. Similarities which were identified in the literature highlighted that most countries had similar goals. The main goal was for instance, assisting students in correlation of theory and practice by clinical facilitation and education during clinical accompaniment. The other important point was by employing mentors who will be based at the clinical facilities to assist students with all their needs during placement. It was also noted that the clinical placement facilities provided the students with the opportunity to experience nursing in the real world thus enabling the students to put theory into practice. Most of the studies recommended an improvement in the collaboration between the training facilities and clinical placement facilities.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In the previous chapter a literature review of an evaluation of clinical training component was presented. The purpose of this chapter is to inform the reader about the research process which was used in this study which is the research approach, research design, research setting, sampling process, instruments used, data collection and data analysis. Inclusion and exclusion criteria are also discussed in this chapter for the reader to understand why the researcher chose the specific participants and excluded others. Students must demonstrate the ability to put theory into practice, therefore, clinical accompaniment is meant to ensure that graduates display the goals of measurable clinical competencies by receiving enough support. Clinical teaching is done by the clinical instructors during clinical accompaniment in clinical facilities where teaching, facilitation, support, guidance and monitoring of students is done. According to Andrews et al. (2006), clinical educational models are influenced by the support received by students in the clinical setting. Figure 1(d) explains the impact of clinical placement on acquisition of clinical skills and the competencies thereof. A model by Andrew et al. (2006) will be guiding this study and its limitations will also be discussed. This chapter concludes with a discussion on ethical considerations of the research.

3.2 RESEARCH DESIGN

According to Burns and Groove (2011), a research design is “the blue print used to conduct a study.” It serves as a guide to planning and implementing a study in a way that is most likely to achieve the intended goal.

An exploratory descriptive design with multiple methods used in this study. According to Polit and Beck (2012), the purpose of a descriptive research design is to observe, describe and document aspects of a situation as it naturally occurs. Burns and Groove (2011) argues that descriptive designs are crafted to gain more

information about characteristics within a particular field of study. A descriptive design can be used to develop theory, identify problems with current practice, justify current practice, make judgements or determine what others in similar situations are doing (Burns and Groove, 2011).

The quantitative design was chosen as it was felt it would be appropriate for assessing the perceptions of the lecturers as well as of the student nurses with regards to clinical facilitation as these were going to be compared between the different groups using predetermined questions. A validated Likert type questionnaire was used to collect quantitative data from the lecturers and students where the questions were structured and one open ended question was included at the end of the questionnaire (Addissie et al., 2014).

The qualitative design was also chosen in order for the clinical instructors to express their challenges as well as to share their experiences in clinical facilitation as they are directly involved in clinical facilitation (Burns and Groove, 2011). Creswell (2009) states that qualitative research design is used to explore and understand the meaning individuals or groups ascribe to a social or human problem. Furthermore Polit and Beck (2012), defines qualitative design as a design that merges various data collection strategies together and is capable of adjusting to new information during data collection whereas quantitative design is an investigation of phenomena that lend themselves to precise measurement and quantification. It often involves a rigorous as well as a controlled design.

3.3 STUDY SETTING

This study was conducted at a University of Technology (UoT), in KwaZulu-Natal situated near a semi-urban area. The students who participated were mostly from the KwaZulu-Natal province and surrounding provinces. They were mostly of Black South African origin and spoke different languages depending on where they came from. English was the main language of communication during facilitation of students at the campus. All lecturers who participated were fully employed and had worked at the UoT for a minimum period of six months. There were 7 lecturers including 1 head of programme (n=7). The lecturers are expected to also do clinical facilitation as well

as accompaniment that is why they were included in order to get their views about clinical facilitation

There were 7 clinical instructors (excluding the researcher) and 1 clinical coordinator (n=8). All the clinical instructors who participated also had an employment period of 6 months and more. They had experience of clinical facilitation since they are the ones who specifically do clinical facilitation and clinical accompaniment

3.4 STUDY POPULATION

The population are all the elements meeting the sample criteria, making them eligible for inclusion in the sample, sometimes known as the target population (Burns and Groove, 2011). The target population in this study consisted of a nursing programme coordinator who was involved in the education and training of the students in this campus, a clinical coordinator who also was involved in clinical teaching and allocation of students, lecturers, clinical instructors and student nurses from three different levels. The target group provided an accessible population. The second, third and fourth year students, which according to Burns and Grove (2011) is that portion of the target population to which the researcher has reasonable access, and according to Polit and Beck (2012,) it is the whole aggregation of cases in which researcher is interested to use in his/her study.

3.5 SAMPLING PROCESS

Sampling is a process of selecting cases to represent an entire population. A sample is a subject of population elements, which are the most basic units about which data are collected (Polit and Beck, 2012). Burns and Groove (2011,) defines a sample as a part or a fraction of a whole, or a subset of a large set, selected by the researcher to participate in a research project. All academic staff, that is: the programme coordinator, clinical coordinator, all lecturers and clinical instructors participated in this study. Purposive sampling was used to select the lecturers and clinical facilitators since they were few in numbers. Purposive sampling is defined by Polit and Beck (2012) as a method where a researcher selects participants using personal judgement on those who will be most informative in the study.

According to Polit and Beck (2012), stratified random sampling is done to enhance representativeness where an appropriate number of elements are selected randomly for the study. Burns and Groove (2011), argues and states that stratified random sampling is used when the researcher knows some of the variables in the population that are important to achieve representativeness. Burns and Groove (2011), further states that the "researcher can use a smaller sample size to achieve the same degree of representativeness relative to the stratified variable that can be derived for a large sample acquired through simple random sampling". All nursing students in three levels were approached to participate in this study since they were involved in clinical facilitation for more than a year. Students were stratified according to year of study. In each level students were further selected using random sampling. They were selected using even numbers, where every second student was selected, excluding those who were in the pilot study. There were 261 nursing students who were not included in the pilot study. All 132 students who were approached after random selection per level participated in the study.

3.5.1 Inclusion criteria:

- Programme coordinator who gives lectures to the students.
- Permanent lecturers who have been employed for more than 6 months minimum at UoT nursing department.
- Clinical coordinator who also does clinical teaching as well as clinical accompaniment to the students,
- Permanent Clinical instructors who have been employed and have a minimum of 6 months working experience at the UoT nursing department and
- Nursing students at fourth year, third year and second year level of study.

3.5.2 Exclusion criteria:

- Part time lecturers, since they were not at the campus at all times, they only come to campus to give lecturers and they do participate in student accompaniment.
- Lecturers and clinical instructors who had less than six months experience.

- First year students since they are in the early stage of their training, they have comparatively limited placement and educational experience and less knowledge of clinical facilitation.
- Those that participated in the pilot study.

3.6 SAMPLE SIZE

According to Polit and Hungler (2001), there is no specific sample size in qualitative research, it depends on the purpose of the research, the quality of the participants and the sampling strategy used. A guiding principle in sample size is “data saturation”, which is the point where no new information is coming forth from the participants. Polit and Beck (2012,) state that data saturation is when themes and categories in the data being collected is repetitive and redundant and there is no new information gained by further data collection.

All clinical instructors participated in the study including the clinical co-ordinator (n=8). Focus group discussions were conducted with the clinical instructors and probing was done during both interviews to obtain as much information. The data was collected until there was repetition of the same information. The clinical instructors were seen in two different days as some were not available on the appointment date. An interview guide was used to collect data (appendix 7).

All the lecturers participated in the study including the programme coordinator (n=7). They all filled in the questionnaires which were posted in a box that was provided at reception in stipulated time.

The students were randomly selected, where there were fourth year nursing students (n=29), third year students (n=36) and second year students (n=67). The total number of students who participated in the study was 132. Data was collected from lecturers and the student nurses using questionnaires (appendices 6a and 6b). All participants gave a written informed consent. (Lapan and Quartaroli, 2009) defines an informed consent as a document used to notify the participants about the type of

study they will participate in, the risks involved, as well as well as their rights. Table 2 depicts the number of participants in this study.

Table 2: Research participants

Participants	**Number**
Programme coordinator	1
Clinical coordinator	1
Lecturers	6
Clinical facilitators	7
Fourth year students	29
Third year students	36
Second year students	67
TOTAL	**147**

3.7 DATA COLLECTION PLAN

Objective 1: To assess the facilitation of the clinical training component by ascertaining the experiences of the clinical instructors during clinical accompaniment by using a focus group interview.

- A qualitative approach was used to meet this objective using an interview guide where 7 clinical instructors and 1 clinical coordinator (n=8) participated in 2 groups in two days.
- The interview guide was piloted.

Objective 2: To assess the facilitation of the clinical training component by ascertaining the **perceptions** of the lecturers.

- A quantitative approach was used to meet this objective by the use of a questionnaire where there were 6 lecturers and 1 head of programme (n=7) who participated.
- The lecturer's questionnaire was piloted.

Objective 3: To assess the facilitation of the clinical training component by ascertaining the perception of the students.

- A quantitative approach was used to meet this objective where a questionnaire was used on 29 fourth year nursing students, 36 third year students and **67** second year students, in all there were 132 nursing students who participated.
- The student's questionnaire was piloted.

Objective 4: To describe the benefits of student accompaniment in the clinical facilities as perceived and experienced by the clinical instructors.

- Both qualitative and quantitative approaches were used to meet this objective where lecturers and students filled questionnaires and clinical instructors had focus group interviews.

3.8 PILOT STUDY

A pilot study was conducted prior to the actual study. A pilot study is defined by Burns and Groove (2011) as a smaller version of a proposed study, conducted to refine the study. Lapan and Quartaroli (2009) states that pilot study is done in order to ensure accuracy, which response format is effective for specific purpose at hand as well as to know how best to lay questions to meet the objectives and layout of your tool.

The following people were approached to be part of the pilot study: 1 lecturer who had worked for over a year as a lecturer and joined clinical instructors piloted the lecturers questionnaire, 1 clinical instructor who worked as a clinical instructor and was a coordinator of the Extended Curriculum Programme (ECP) piloted the interview guide, and 5 students per level piloted the students questionnaire. Participants in the pilot study volunteered after details of the study were explained to them and all participants signed a written informed consent. Participants in the pilot study did not participate in the main study.

The findings from the pilot study suggested that a few technical changes needed to be made to the interview guide as well as the questionnaire. A change to recruiting from different levels of study of students was made since during data collection all students had progressed to the next level. Fourth year level was added in the students' questionnaire since the third year level students were then in their fourth year level of study. First year students were removed since they were still very new in the course and it also became clear that the interviews would be guided by the responses of the participants and probing was to be done to obtain more information from each participant (Table 2).

3.9 DATA COLLECTION PROCESS

When data are collected an instrument is developed or borrowed, which is a formal written document used to collect and record data (Polit and Beck 2012). For the quantitative part of the study a questionnaire which was used by Peter (2008) who did a study in Limpopo was used (appendices 6a and 6b). The questionnaire was adapted to answer the objectives of this study and it was validated by way of a pilot study. A questionnaire is defined by Burns and Groove (2011) as a printed self-report form designed to elicit information that can be obtained through written or verbal responses of the subject.

The questionnaires had both open-ended and closed-ended questions to collect data from the lecturers and student nurses (Appendix 6a and 6b). The questionnaire had four sections, section A was used for collecting demographic information, section B was used to establish the perceptions of the lecturers' and students' on clinical placement area, section C was used to evaluate the clinical facilitation of clinical teaching and learning and section D was used to evaluate progress of clinical assessment. The questionnaires were emailed to all lecturers, who were asked to post them in a box which was provided in the front desk at reception within a week of receiving the questionnaire. The return rate was 100% for lecturers and 100% for students.

Students were met on different set dates per level of study, where they were given questionnaires to fill in. They then posted the questionnaires in a box that was on the

front table in class. It took about 30 minutes to fill in the questionnaire. Table 3 highlights how the questionnaire was divided into different sections.

Table 3: Four sections in the questionnaires used for collecting data from lecturers and nursing students

SECTION A	SECTION B	SECTION C	SECTION D
Demographic information:	Clinical placement area: Question 1 to 13	Clinical teaching and learning: Question 14 to 23	Clinical assessment: Question 24 to 32

3.9.1 Reliability Statistics of the questionnaires

Table 3a and 3b reflects the Cronbach's alpha score for all the items that constituted the questionnaires. A reliability coefficient of 0.70 or higher is considered as "acceptable" (Singh, 2013). The overall reliability scores of the questionnaires were 0.877 and 0.750 and they exceeded the recommended value of 0.700. This indicates a high (overall) degree of acceptable, consistent scoring for this research therefore, almost all of the individual sections also met the required reliability value.

Table 3a: items constituted in the student's questionnaire

Sections	Number of Items	Cronbach's Alpha
SECTION B: Clinical Placement area	12 of 12	.828
SECTION C: Clinical teaching and learning	14 of 14	.698
SECTION D: Clinical assessment	8 of 8	.821
Overall	**34 of 34**	**.877**

Table 3b: Items constituted in the lecturer's questionnaire

Section	Number of Items	Cronbach's Alpha
SECTION B: Clinical Placement area	13 of 13	0.820
SECTION C: Clinical teaching and learning	10 of 10	0.720
SECTION D: Clinical assessment	9 of 9	0.650
Overall	**32 of 32**	**0.750**

For the qualitative part of the study a focus group discussions using an interview guide (appendix 7) with structured and semi-structured questions was used, since the response rate tends to be high with face-to-face interviews (Polit and Beck, 2012). An interview is a verbal communication between the researcher and the participant during which information is provided to the researcher (Burns and Groove 2011). This type of interview allowed the participants to have a chance to express their opinions and feelings on the phenomenon without the restrictions of closed ended questions or the interviewer's opinions (Burns and Grove 2011).

The interview guide was divided into four sections (Table 4).

Table 4: Four sections of the interview guide

SECTION A	SECTION B	SECTION C	SECTION D
Role of a clinical instructor	Experiences faced by clinical instructors	Benefits of clinical facilitation and clinical accompaniment to students	Recommendations on the development of an accompaniment tool that will assist lecturers and clinical instructors during accompaniment

The interview took place in a boardroom where there were no disturbances and it was quiet. The interview was planned during the lunch break and the participants were able to eat. The researcher guided the discussion using a pre-formulated

interview guide with open-ended and closed-ended questions that were guided by the model adapted from Andrews et al. (2006) (Figure 1 (d)) as well as the objectives of the study. The interviews were conducted in English. A question was read from the interview guide and the participants gave each other a chance to answer. Each participant had an opportunity to air their views on the topic and there was no interruption during the discussion. Everybody participated with no disturbance, all opinions were sought. The interview took two days since some clinical instructors were unavailable on the day of the appointment, and everyone had a chance to answer the questions. A Dictaphone was used to record the discussion. The participants gave permission for the interview to be recorded. This was also stated in their letter of information. The interview took about 50 minutes on day 1 and 45 minutes on day 2 for the second group, and the participants were able to answer all questions. The researcher also had hand written notes of what was said by the participants in order to compare with what was recorded and to make sure that nothing was missed. The information was then transcribed in English by the researcher.

3.10 A MODEL THAT GUIDED THIS STUDY

When all the interviews were done, a model was used to categorize findings as they emerged. This study was the guided by a model by Andrews et al. (2006), referred to as clinical placement education model (Figure 1(d)).

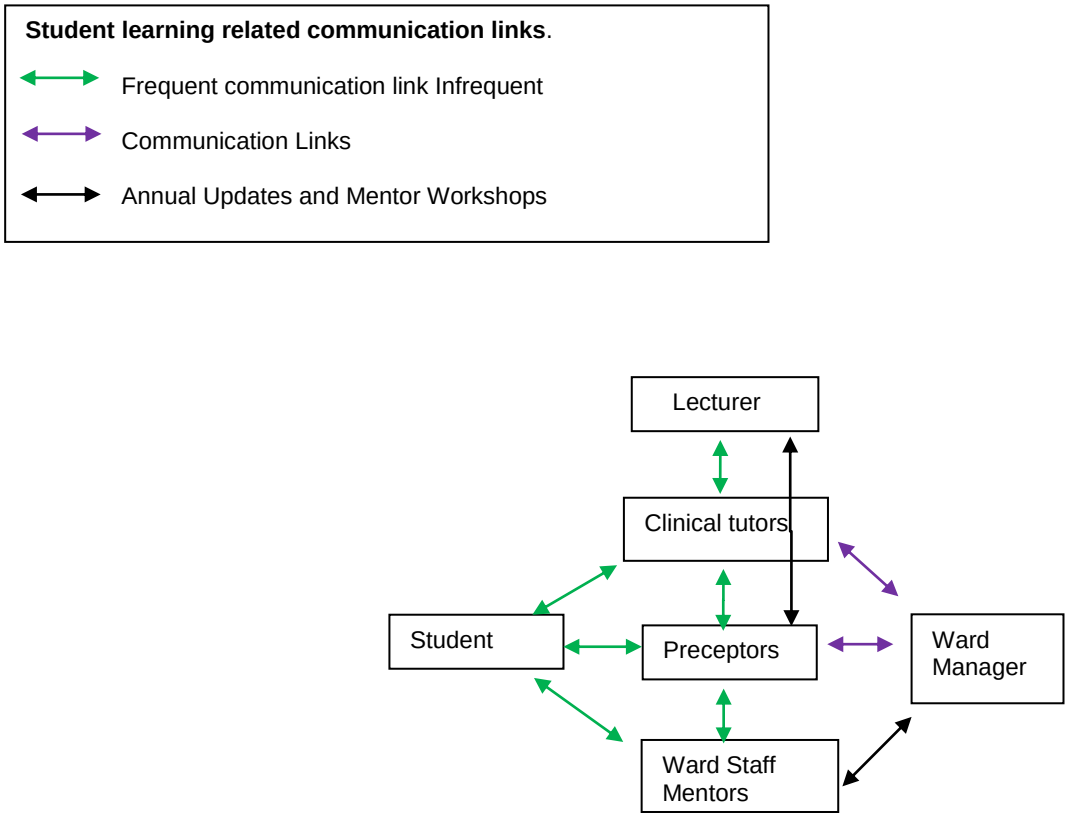


Figure 1(d) Recommended 'best practice' Andrews et al. (2006)

3.11 DATA ANALYSIS, DATA MANAGEMENT and DISSEMINATION OF DATA

3.11.1 Quantitative data analysis

Data was analysed using SPSS version 21.0 where descriptive statistics using frequency and cross-tabulation tables and various types of graphs (including pie charts, bar charts, etc.) were used to represent the findings of the research.

- Inferential statistics was performed using Spearman's correlations at a significance level of 0.05
- Testing of hypotheses was done by using chi-square tests for nominal data and ordinal data at a level of significance of 0.05
- Data reliability was determined by using Cronbach's Alpha (Table 3 (a and b)
- The data was reduced and analysed with the help of a statistician, using the statistical software SPSS version 21.0.

3.11.2 Qualitative data analysis

Interpretive data analysis technique was used to analyse data, where three stages were used to analyse data namely: description, analysis and interpretation, as described by Burns and Grove (2011):

(a) Description phase: In this phase the researcher listened to the interviews over and over again from the audio tape recorder to try and understand, describe and analyse the information. The researcher also read the summary that was written during the interview for the purpose of getting immersed in the data and interpreting it in order to try and make sense of it, comparing it with the information in the tape recorder (Burns and Grove, 2011).

(b) Analysis phase: Themes and sub themes were identified from the raw data to establish patterns emerging from the raw data and these were used to interpret data manually. By reading the extracts this led to discovering keywords and processes which captured the essence of the narrative data (Burns and Grove, 2011). After analysing all the raw data it was then interpreted.

(b) Interpretation: Themes and sub themes were identified during the data analysis phase using the researcher's own understanding and interpretation. This was then supported by the supervisors after they also listened to the tape. Thus bias and subjectivity was eliminated. The literature reviewed also assisted in verifying findings.

3.12. RIGOUR AND TRUSTWORTHINESS

The reliability of the collected quantitative data was indicated by the Cronbach's alpha reliability scores of 0.877 and 0.750 for the students' and lecturers' questionnaires respectively, which exceeded the recommended value of 0.700 (Table 3(a) and 3(b)). This indicates a high (overall) degree of acceptable (Singh, 2013).

It is also important that in a qualitative research validity and reliability are ensured since in qualitative research there is usually criticism and subjectivity (Polit and Beck, 2012). In this study trustworthiness was ensured by following a certain criteria: credibility, transferability, dependability and conformability (Polit and Beck, 2012).

The following were used to ensure trustworthiness or validity of data in this study:

3.12.1. Credibility

Credibility can be ensured in various approaches. According to Polit and Beck (2012), it is achieved to the extent that the research methods ensure confidence in the truth of the data and how the researcher interprets it. In this study credibility was ensured by interviewing all the clinical instructors and writing short notes during the group interview. This was also ensured by recording the interview with the permission of the participants. The participants were probed during an interview until there was data saturation. Detailed notes were written immediately after the interview while the researcher remembered the conversation. The tape was played over and over again during transcription of the information to make sure that correct

information was recorded. After transcribing all the information, the report was shared with the participants to make sure that the correct information was recorded. The participants confirmed the information. Themes were then formed from the information obtained during the interview.

3.12.2. Dependability

According to Polit and Beck (2012), dependability is the consistency and stability of data collected. In this study data was collected from the clinical instructors who were directly involved in clinical training of the students and who had been working for at least six months and above. An audit trail was maintained by ensuring that raw information that was collected from participants during the focus group interview was kept safe for future reference. It is essential that the collected data is scrutinised for auditing by an external reviewer. In this study this was done by the supervisor who ensured dependability. Notes which were written during an interview, disc of interviews and consent forms were kept safe in a locked safe.

3.12.3. Confirmability

Polit and Beck (2012), states that confirmability is the degree to which study results are derived from characteristics of participants and the study context, not from researchers biases. In qualitative research it focuses on the characteristics of data gathered in the study and by using an audit trail. Creswell (2009,) calls it member checking to determine qualitative findings by sharing the final reports or themes with the participants to confirm accuracy. In this study bias was eliminated by the interpretation of data by the researcher where raw data was confirmed by the use of direct quotes from the raw data to eliminate subjectivity. Recorded voices during the interview were transcribed, thereafter the participants were asked to review the transcribed interview and were asked to confirm if the notes were a true reflection of what they said during interviews regarding clinical facilitation. An independent coder who was my supervisor also scrutinised the interpretation of data theme and responses identified by the researcher and they were contrasted with those identified by the supervisor. There were no major discrepancies identified in the data analysed.

3.12.4. Transferability

Transferability according to Lincoln and Guba (1985) cited by Polit and Beck (2012), is judgements about whether findings from the enquiry can be extrapolated to a different setting or group of people. In this study transferability was ensured by a thorough description of research setting, participants in the study and the research processes.

3.12.5 Authenticity

Lincoln and Guba (1985) cited by Polit and Beck (2013), also adds authenticity under trustworthiness whereby the researcher fairly and faithfully shows the range of different realities. The researcher strived to ensure authenticity by using direct narratives by the study participants and this ensured that the feeling tone of the study participants was conveyed as it was lived and the researcher ensured that the readers will understand the portrayed lives better because mood and feelings are portrayed in the study. In quantitative study validity and reliability was ensured by the pilot by using the same questionnaires that were used in the main study.

3.13. ETHICAL CONSIDERATIONS

Ethical clearance was obtained from the Ethics Committee of the Durban University of Technology (Appendix 1(a)). The Research Director granted permission to conduct the study on students (Appendix 2b). The Head of Department (HOD): Nursing also granted permission to conduct the study in the department (Appendix 3b). The researcher made presentation to the lecturers and clinical instructors during a staff meeting explaining the purpose of the study. All the participants signed informed consent forms before participating in the study. Thereafter, the questionnaires, adapted from Peter (2008) (Appendix 6a) were emailed to the lecturers to fill in during their spare time and a box was placed at reception for completed questionnaires to be posted.

An appointment was made with the clinical instructors for focus group discussions using an interview guide (Appendix 7). The researcher held a meeting with the

students of different levels of study on different days during their study period, to explain the purpose of the study and for sample selection. A date was chosen for each level to meet so that they can fill in the questionnaire (Appendix 6b).

Informed consent form (Appendix 5) was signed by all participants**.** All participants were assured of voluntary participation. Willing participants signed a written consent form after reading and understanding the information letter (Appendix 3). Participants were informed that they could withdraw from the study at any stage, if they so wished, with no questions asked and that there will be no penalty for participants. Participants were assured of total anonymity at all times since their names were not used on the questionnaires. The clinical instructors agreed to maintain confidentiality during the focus group interview since the interviewer knew them as she worked with them. They were also assured that their participation in this study will not impact on the daily team work with the researcher. Students were also assured that this would not change the way they will be treated in the campus. They were informed that the findings and recommendations would be made available to the research authorities and a copy would be kept in the University library.

Data was stored under lock and key for the duration of the study and the tapes will be deleted and hard copy materials will be shredded for safety of information after 15 years as per the UoT Faculty of Health Sciences Research Committee policy.

The following ethics principles were observed:

3.13.1 Beneficence

Beneficence in research should be ensured so that there would be no harm to the participants but maximum benefits (Polit and Beck, 2012). In this study the right to freedom from harm and discomfort was maintained as participants were not subjected to any risk of harm or injury. This was ensured by explaining to all participants about their rights to freedom from harm and discomfort and there was no harm as the participants only filled questionnaires. The participants were also given a chance to verbalize their concerns and questions before signing the informed consent forms. Those who were interviewed were also assured that everything they

said was confidential and that there will be no emotional harm. The other preventative measure was to get approval from the Head of Nursing Department for the staff members and another one from the postgraduate research office to protect the students. All participants were informed about their right to withdraw at any time with no questions asked, also that there would be no incentive for the participants.

3.13.2 Respect for human dignity

A letter of information was given to all participants and it explained the purpose of the study, risks and discomfort. The letter also explained the importance of confidentiality where the study anonymity was ensured by not using or mentioning anybody's name during the focus group interview. After all the explanations participants were then asked to sign the consent forms. Polit and Beck defines respect for human dignity as self-determination which is the right to participate or withdraw from the study at any time when they feel uncomfortable (Polit and Beck, 2012).

3.13.3 Justice

Justice is defined by Polit and Beck (2012), as treating participants fairly and ensuring privacy. In this study this was ensured by approaching clinical facilitators who are involved and have experience with the clinical facilitation. The right to privacy was also maintained by keeping collected data under lock and key with the password only known by the researcher and the supervisor. The focus group interview was also carried out in the boardroom which was private with no disturbances. All participants were allowed to ask questions and to refuse to give information to ensure their self-determination.

3.14 CONCLUSION

A review of methodology of this research was discussed in this chapter. Different steps of the research process and ethical considerations were discussed. During qualitative data analysis themes and sub-themes were identified from the raw data to establish patterns emerging from the raw data and these were used to interpret data manually. The large sample in the quantitative data made it easy to identify follow up questions for the focus group interview during data collection. Research findings are discussed in the next chapter

CHAPTER 4

PRESENTATION OF RESULTS

4.1 INTRODUCTION

In the previous chapter research methodology was presented where the research process was discussed. In this chapter, data is organized systematically and synthesized (Polit and Hungler, 2001). Quantitative and qualitative data is analysed and results presented. The aim of this study was to assess the clinical training component of the undergraduate nursing programme at a UoT. As described in chapter 3 a total of 7 lecturers and 132 students were recruited for quantitative data collection and 8 clinical instructors for qualitative data collection. These are analyzed separately.

All students who participated had experience with clinical facilitation, as data was collected towards the end of the year in 2013 and students had enough exposure that enabled them to relate their experiences in clinical practice. All nursing students are expected to cover a minimum of 1000 hours per year per level of study. These hours are allocated into different clinical departments and modules, which the students have to undertake at the time of allocation.

4.2 STATEMENT OF FINDINGS, INTERPRETATION AND DISCUSSION OF THE QUANTITATIVE PRIMARY DATA

The results and discussion of the findings obtained from the questionnaires in this study will be presented in this section. The questionnaire was used to collect data and was distributed to students and lecturers at this campus. The data collected from the responses was analysed with SPSS version 21.0.The results present the descriptive statistics in the form of graphs, cross tabulations and other figures for the quantitative data that was collected. Inferential techniques include the use of correlations and chi square test values; which are interpreted using the p-values.

4.2.1 THE RESEARCH INSTRUMENT

The research instrument, the questionnaire consisted of 36 items for the lecturers' questionnaire (appendix 6a) and 37 items for the students' questionnaire (appendix 6b), with a level of measurement at a nominal or an ordinal level. Each questionnaire was divided into 4 sections which measured various themes as illustrated below:

SECTION A - Biographical data
SECTION B – Clinical Placement area
SECTION C - Clinical teaching and learning
SECTION D - Clinical assessment

In each questionnaire there were 5 responses to choose from (Likert Scale), that is: 'strongly agree', 'agree', 'disagree', 'strongly disagree' and 'neither agree nor disagree'. However, during data analysis levels of disagreement (negative statements) were collapsed to show a single category of "disagree". A similar procedure was followed for the levels of agreement (positive statements). The responses were thus analysed in a three point scale. This is allowed due to the acceptable levels of reliability (Singh, 2013).

The number of students' questionnaire returns constituted a 100% return rate (n=132) and, all 7 lecturers responded, which was a return rate of 100%.

4.3 PRESENTATION OF QUANTITATIVE DATA

4.3.1 SECTION A - Biographical data

This section summarises the biographical characteristics of the questionnaire respondents, which are both, students and lecturers.

4.3.1.1 Students

In total, 132 students were surveyed, where the majority of them (n=67; 50.7%) were in the second year level of study (Table 5). Table 5 depicts that students in all the

levels of study, who had been exposed to clinical facilitation were represented. The students' sample size, according to the statistician had been calculated to be 132 participants (Singh, 2013).

Table 5: The total number of students who participated in the study per level of study

LEVEL OF STUDY	NUMBER	PECENTAGE
4TH	29	22%
3RD	36	27.3%
2ND	67	50.7%
TOTAL	**132**	**100%**

Figure 4 indicates the number of students who participated per level of study, where slightly more than half of them (50.7%) were in the 2nd level of study, 27.3% in the third year level, and with the smallest grouping (22.%) being 4th year level students.

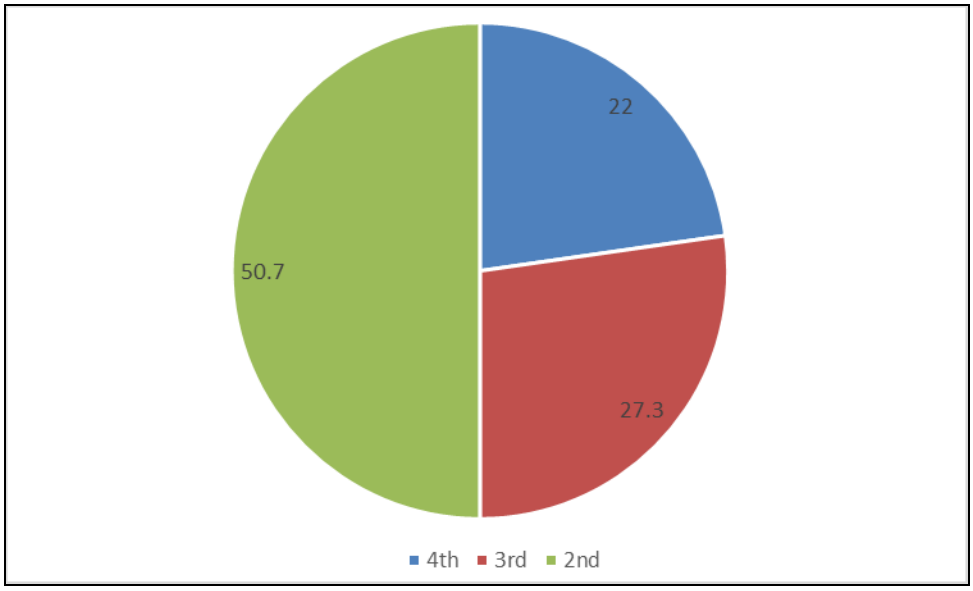


Figure 4: Level of study of the students

It is noted that the student ratio of females to males was approximately 2:1 (68.2%: 31.8%), however in the 25 to less than 30 years' age group and in the more than 35 years' age group there was 1:1 female: male ratio (50% each) (Table 6).

Table 6: Gender distribution of students by age

AGE	FEMALES	FEMALE PERCENTAGE	MALES	MALE PERCENTAGE
15 - < 20	32	71.1	13	28.9
20 - < 25	50	67.6	24	32.4
25 - < 30	3	50	3	50
30 - < 35	4	80	1	20
>35	1	50	1	50
TOTAL	**90**	**68.2**	**42**	**31.8**

The majority of students were in the 20 to less than 25 years' age group (n=50), where 67.6% of them were females and 32.4% were males (Table 6).

Figure 5 shows that despite the general student ratio of females to males was approximately 2:1 in most of the groups, however, the 30 to less than 35 year age group female to male ratio was 4:1 and in both the 25 to less than 30 years' age group and the more than 35 years' age group the ratios were 1:1.

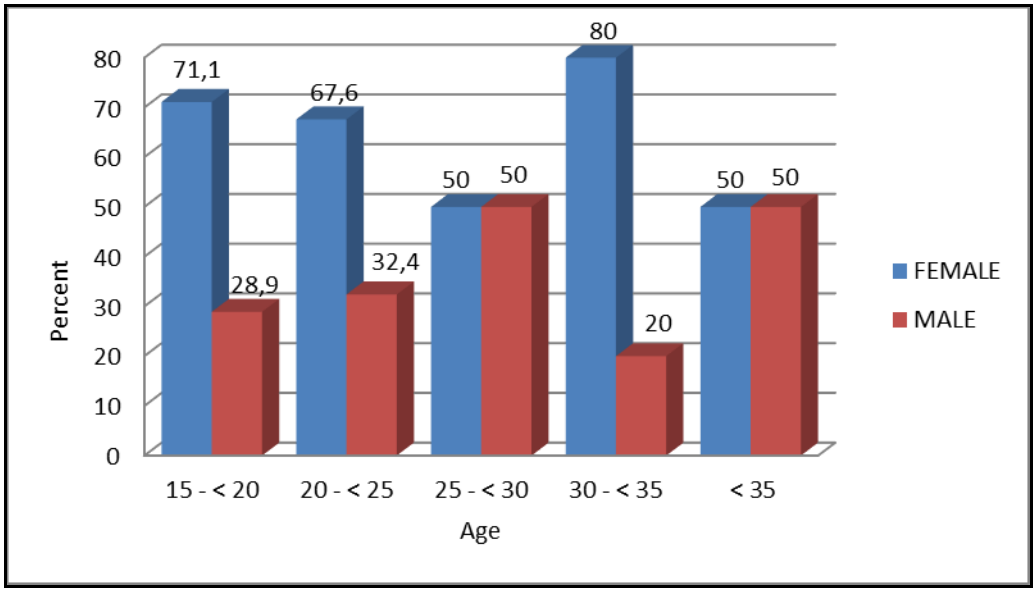


Figure 5: Gender distribution of students by age

Generally, male students were in the minority in most of the age groups (Figure 5).

4.3.1.2 Lecturers

It is noted that all lecturers (n=7) who participated were all females. Table 7 depicts the age distribution among the lecturers, noting that 57.1% of them were older than 60 years of age (Table 7).

Table 7: gender distribution of lecturers by age

AGE	GENDER	NUMBER	PERCENTAGE
30 - < 40	Female	1	14.3%
40 - < 50	Female	1	14.3%
50 - < 60	Female	1	14.3%
60 - < 70	Female	4	57.1%
TOTAL	**FEMALES**	**7**	**100%**

Figure 6 denotes the age distribution of the lecturers showing that the majority of the respondents were older than 60 years of age (n=4).

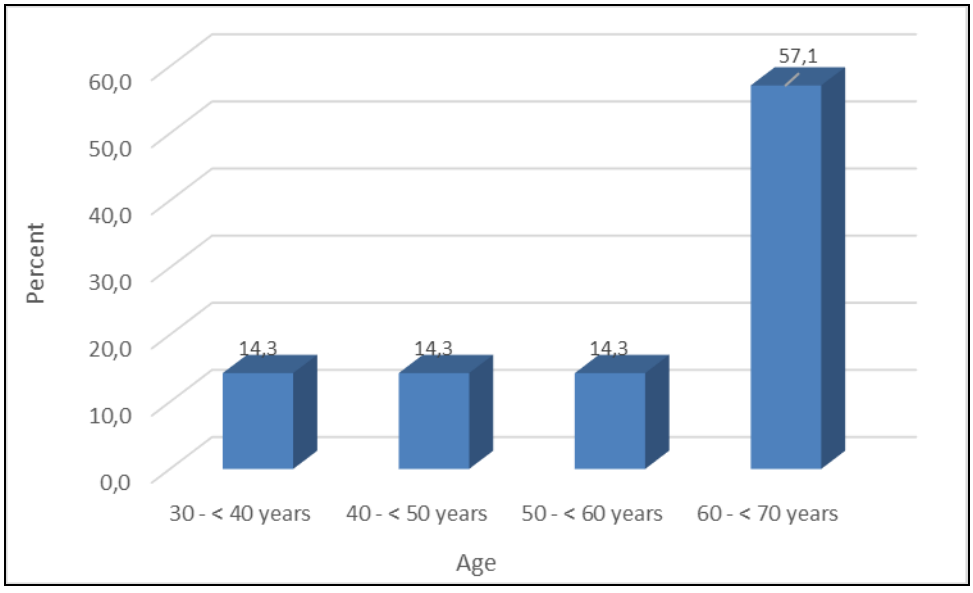


Figure 6: Age distribution of the lecturers

Furthermore, 71.4% of the lecturers had a working experience of two years and more at the UoT (Figure 7). A little more than a quarter (28.6%) indicated that they had been at the campus for less than 2 years.

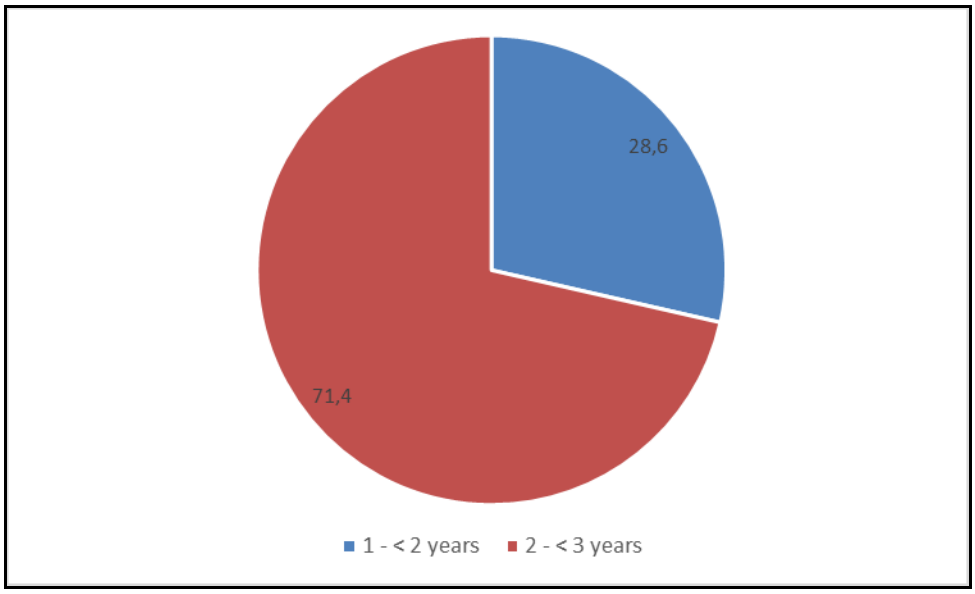


Figure 7: Years of service of lecturers at the campus

4.3.2 DESCRIPTION OF STATISTICAL DATA

This section summarises the scoring patterns of the respondents which are, students and lecturers, per variable per section of the questionnaire. The responses are reported as they appeared in the questionnaire, i.e. sections B, C, and D. The description was discussed in a three point scale which was a summary. It combined agree and strongly agree, disagree and strongly disagree as it could not be distinguished between the two groups. However five point scales were used for all the technical and inferential statistics. The students' responses will be reported noting the differences per statement across the levels of study, with p values indicating whether there was statistical significance in those differences. A significant result is indicated with $p < 0.05$ generated from a chi square test (Singh, 2013). Thus, results that have a $p > 0.05$ do not have statistical significance.

4.3.2.1 Students

4.3.2.1.1 SECTION B: Clinical placement area

Table 8 shows the responses of the students from the three different levels of study regarding the clinical placement area.

There were 12 questions on section B of the students' questionnaire (Table 8) and the analysis shows that 63% of fourth year students agreed that placement dates are pre-published before the placement of students to the clinical facilities, 3.3% were neutral and another 33.3% disagreed. Third year students on the other hand 71.4% agreed that placement dates are pre-published before the placement of students to the clinical facilities, 2.9% were neutral and 25.7% disagreed with this. With the second year students, 93.9% agreed that placement dates are pre-published before the placement of students to the clinical facilities, as little as 1.5% were neutral and 4.5% of students disagreed with this statement ($p = 0.017$).

Seventy three percent of fourth year students agreed that they received a manual containing all the rules regarding clinical practice, procedures, forms and strategies prior to commencement of clinical placements and 26.7% disagreed with this statement. With third year students 77.7% also agreed that they received a manual containing all rules regarding clinical practice, procedures, forms and strategies prior to commencement of clinical placements, 5.1% were neutral and as little as 17.1% disagreed. With regards to the second year students, 89.2% agreed, 3.1% were neutral and 7.7% disagreed that they received a manual containing all rules regarding clinical practice, procedures, forms and strategies prior to commencement of clinical placements ($p = 0.087$).

Table 8: A summary of the scoring patterns of the students on clinical placement area

		4th			3rd			2nd		
		Agree	Neutral	Disagree	Agree	Neutral	Disagree	Agree	Neutral	Disagree
Placement dates are pre-published before the placement of students to the clinical facilities	B1	63.3	3.3	33.3	71.4	2.9	25.7	93.9	1.5	4.5
We receive a manual containing all rules regarding clinical practice, procedures, forms and strategies prior to commencement of clinical placements	B2	73.3	0.0	26.7	77.1	5.7	17.1	89.2	3.1	7.7
I get enough clinical exposure in the clinical placements	B3	56.7	0.0	43.3	34.3	2.9	62.9	68.2	3.0	28.8
There is enough clinical accompaniment by clinical instructors when we are in the placement area	B4	40.0	3.3	56.7	58.3	2.8	38.9	78.5	3.1	18.5
Students and clinical facilitators have effective communication re- learning outcomes	B5	53.3	3.3	43.3	69.4	8.3	22.2	56.9	7.7	35.4
There is an effective communication between clinical facilitators and staff in the clinical facilities re- learning outcomes	B6	40.0	13.3	46.7	61.1	13.9	25.0	66.2	9.2	24.6
We as students and clinical facilitators have effective communication re- expectations during clinical placements	B7	50.0	10.0	40.0	61.1	11.1	27.8	74.2	4.5	21.2
There is effective communication between clinical facilitators and clinical staff re-expectations during clinical placement	B8	40.0	10.0	50.0	47.2	16.7	36.1	65.2	9.1	25.8
Student's learning outcomes are distributed to the placement area before placement of students	B9	43.3	6.7	50.0	52.8	25.0	22.2	71.9	10.9	17.2
The learning needs of students are clarified to us as students	B10	23.3	10.0	66.7	66.7	16.7	16.7	76.9	6.2	16.9
The clinical facilities are supportive of professional growth, skills development and practice of students.	B11	63.3	3.3	33.3	75.0	13.9	11.1	81.8	3.0	15.2
There are enough clinical placement facilities to place students for clinical practice	B12	55.2	3.4	41.4	30.6	13.9	55.6	50.0	10.6	39.4

All the students answered this item and 56.7% fourth year students agreed that they get enough clinical exposure in the clinical placement and 43.3% disagreed. On the other hand, 34.3% of the third year students agreed, 2.9% were neutral and 62.9% disagreed with this issue. The highest percentage of second year students (68.2%) agreed with this statement, as little as 3.0% were neutral and 28.8% disagreed (p=0.059).

Some of the fourth year students which were 40% agreed that there was enough clinical accompaniments by clinical instructors when they are in the placement area, 3.3% were neutral and 56.7% disagreed, whereas 58.3% third year students agreed, 2.8% were neutral and 38.9% disagreed. With the second year students 78.5% agreed, 3.1% were neutral and 18.1% disagreed (p=0.059).

Most fourth year students which were 53.3% agreed that they have effective communication with the clinical facilitators regarding learning outcomes, 3.3% were neutral and 43.3% disagreed, whereas 69.4% third year students seemed to agree more than the fourth year students, 8.3% were neutral and 22.2% disagreed. With the second year students, 56.9% agreed, 7.7% were neutral and 35.4% disagreed (p=0.048).

As little as 40% fourth year students agreed that there is an effective communication between clinical facilitators and staff in the clinical facilities regarding learning outcomes, 13.3% were neutral and 46.7% disagreed with this; however, 61.1% of third year students agreed, 13.9% were neutral and 25% disagreed with the statement, and as many as 66.2% of the second year students agreed, 9.2% were neutral and 24.6% disagreed (p=0.469); 50% of the fourth year students agreed that they have effective communication with the clinical facilitators regarding expectations during clinical placements, 10% of the students were neutral and 40% disagreed with this statement; but 61.1% of third years students agreed, 11.1% were neutral and 27.8% disagreed with it; however a high percentage, 74.2%, of second year students agreed,4.5% were neutral and 21.2% disagreed (p=0.211).

In this item 40% of fourth year students agree that there is effective communication between clinical facilitators and clinical staff regarding expectations during clinical

placement, 10% were neutral and 50% disagreed. With the third year students 47.2%, agreed that there was effective communication between clinical facilitators and clinical staff regarding expectations during clinical placement, 16.7% were neutral and 36.1% disagreed with this. Many of the second year students (65.2%) agreed that there is effective communication between clinical facilitators and clinical staff regarding expectations during clinical placement, 9.1% were neutral and 25.8% disagreed with the statement (p=0.262).

All the students answered this item and 43.3% of fourth year students agreed that student's learning outcomes are distributed to the placement area before placement of students, but 6.7% were neutral and 50% disagreed. With the third year students, 52.8% agreed, 25% were neutral and 22.2% disagreed, and a high percentage of second year students (71.9%) agreed, 10.9% were neutral and as low as 17.2% disagreed (p=0.10).

About a quarter of the fourth year students (23.3%) agreed that their learning needs are clarified to them, 10% were neutral and 66.7% disagreed; on the other hand 66.7% of third year students agreed,16.7% were neutral and 16.7% disagreed. A high percentage of the second year students (76.9%), agreed that their learning needs are clarified to them, a few, 6.2% were neutral and 16.9% disagreed (p=0.000). Sixty three point three percent of fourth year students agreed that the clinical facilities are supportive of professional growth, skills development and practice of students, whereas 3.3%, were neutral and 33.3% disagreed. Third years had 75% of students who agreed, 13.9% were neutral and 11.1% who disagreed. Again, there were a high percentage of second year students (81.8%) who agreed, as low as 3% were neutral and 15.2% were in disagreement (p=0.007).

Lastly, 55.2% of fourth year students agreed that there are enough clinical placement facilities to place students for clinical practice, 3.4% of them were neutral and 41.4% disagreed. Among the third year students there were 30.6% who agreed, 13.9% were neutral and 55.6% disagreed; 50% of the second year students agreed, 10.6% were neutral and 39.4% disagreed (p=0.260).

Figure 8 shows the average overall score for Section B which indicates that generally more of the second level students (72.7%) were in agreement with most statements compared to the fourth year level students.

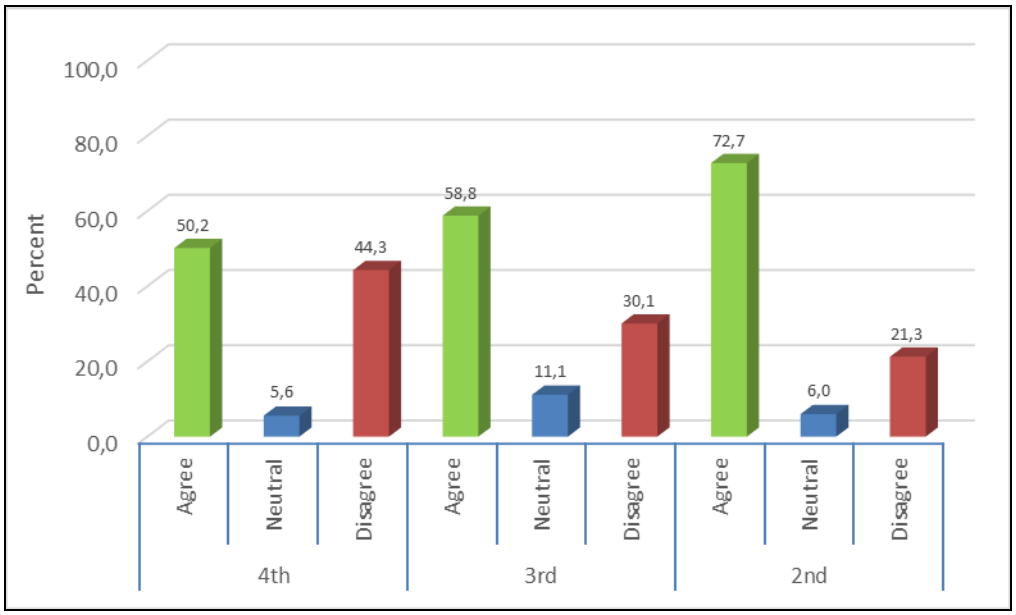


Figure 8: The average overall score for Section B of the students' questionnaire

It was also noted that 50% of the fourth year level students agreed with most statements in Section B and 44.3% of the fourth year level students disagreed with most statements in Section B (Figure 8).

4.3.2.1.2 SECTION C: Clinical teaching and learning

There were 14 questions on Section C of the students' questionnaire (Table 9) and the analysis showed the following:

As little as 23.3% of fourth year students agreed that the university had enough space for clinical teaching and learning activities, 20% were unsure and 56.7% disagreed. With the third year students 41.7% agreed, 16.7% were neutral and 41.7% disagreed that the university has enough space for clinical teaching and learning activities. Whereas 29.7% of the second year students agreed that the university had enough space for clinical teaching and learning activities and only 23.4% were neutral and 46.9% disagreed with that (p=0.214).

Table 9: Summary of the scoring patterns on Clinical teaching and learning in Section C

		4th			3rd			2nd		
		Agree	Neutral	Disagree	Agree	Neutral	Disagree	Agree	Neutral	Disagree
The university has enough space for clinical teaching and learning activities	C13	23.3	20.0	56.7	41.7	16.7	41.7	29.7	23.4	46.9
The university has enough equipment and material resources for demonstration and feedback of clinical skills	C14	46.7	3.3	50.0	44.4	8.3	47.2	43.1	13.8	43.1
The clinical placement areas have enough equipment and material resources for demonstration and feedback of clinical skills	C15	63.3	3.3	33.3	58.3	11.1	30.6	56.1	9.1	34.8
The term "self-directed learning" is clear to us as nursing students	C16	53.3	3.3	43.3	50.0	11.1	38.9	69.2	7.7	23.1
As a student I understand my responsibilities regarding clinical facilitation	C17	63.3	3.3	33.3	80.6	5.6	13.9	78.8	3.0	18.2
We are theoretically prepared before we go for clinical facilitation.	C18	86.2	3.4	10.3	77.8	5.6	16.7	85.9	4.7	9.4
As a nursing student I am willing to learn	C19	82.8	0.0	17.2	91.7	2.8	5.6	90.6	0.0	9.4
Students accept constructive criticism	C20	83.3	6.7	10.0	83.3	0.0	16.7	77.0	3.3	19.7
All students know the limitations of clinical teaching and learning process	C21	70.0	13.3	16.7	69.4	5.6	25.0	69.2	12.3	18.5
Remedial plan is implemented when we as students are not yet competent in a certain skill.	C22	60.0	16.7	23.3	88.9	2.8	8.3	83.3	3.0	13.6
As a student I benefit from clinical accompaniment when allocated in different clinical facilities.	C23	66.7	6.7	26.7	77.8	2.8	19.4	83.3	4.5	12.1
Student clinical accompaniment should only be done by clinical facilitators.	C24	40.0	6.7	53.3	72.2	8.3	19.4	63.6	7.6	28.8
Lecturers should not be involved in clinical accompaniment of students.	C25	43.3	10.0	46.7	47.2	19.4	33.3	39.4	18.2	42.4
Lecturers are involved in student clinical facilitation and accompaniment.	C26	40.0	3.3	56.7	50.0	8.3	41.7	66.7	12.1	21.2

A maximum of 46.7% fourth year students agreed that the university had enough equipment and material resources for demonstration and feedback of clinical skills, 3.3% were neutral and 50% disagreed; 44.4% of third year students agreed, 8,3% were neutral and 47.2% disagreed that the university had enough equipment and material resources for demonstration and feedback of clinical skills. Of the second year students, 43.1% agreed that the university had enough equipment and material resources for demonstration and feedback of clinical skills, 13.8% were neutral and 43.1% disagreed ($p = 0.736$) .

More than half of the fourth year students 63.3% agreed that the clinical placement areas had enough equipment and material resources for demonstration and feedback of clinical skills, 3.3% were neutral and 33.3% disagreed. Third year students 58.3% agreed, 11.1% were neutral and 30.6% disagreed; and 56.1% of second year students agreed, 9.1% were neutral and 34.8% disagreed ($p= 0.736$).

More than half (53.3%) of fourth year students agreed that the term “self-directed learning” was clear to them as nursing students, 3.3% were neutral and 43.3% disagreed that they knew what the term meant. Third year students (50%) agreed that the term “self-directed learning” was clear to them as nursing students, however, 11.1% were neutral and 38.9% disagreed that they knew what the term meant, whereas 69.2% of second year students agreed that the term “self-directed learning” was clear to them as nursing students, but 7.7% were neutral and 23.1% disagreed that they knew what the term meant ($p = 0.173$).

Most of the fourth year students (63.3%) agreed that as students they understood their responsibilities regarding clinical facilitation, 3.3% were neutral and 33.3% disagreed with that. On the other hand, 80.6% of third year students agreed that they understood their responsibilities regarding clinical facilitation, 5.6% were neutral and 13.9% disagreed. Whereas 78.8% of second year students agreed that they understood their responsibilities regarding clinical facilitation, 3.0% remained neutral and 18.2% disagreed ($p = 0.22$).

As many as 86.2% of fourth year students agreed that they were theoretically prepared before they went for clinical facilitation, whereas 3.4% were neutral and 10.3% disagreed. Third year level had 77.8% of students agreeing that they were theoretically prepared before they went for clinical facilitation, 5.6% remained neutral and 16.7% disagreed and 85.9% of second year students also agreed that they were theoretically prepared before they went for clinical facilitation, 4.7% were neutral and 9.4% disagreed (p = 0.549).

Many of the fourth year students 82.8% agreed that as nursing students they were willing to learn and 17.2% disagreed. Of the third year students, 91.7% said that they are willing to learn, 2.8% were unsure and 5.6% disagreed. The highest percentage of second year students (90.6%) agreed that as nursing students they were willing to learn and only 9.4% disagreed (p = 0.112).

More than half 83.3% of fourth year students accepted constructive criticism, 6.7% were unsure and 10% disagreed. Most of the third year students (83.3%) agreed that they accepted constructive criticism and 16.7% disagreed and 77.7% of students in the second year level agreed that they accepted constructive criticism, but 3.3% were neutral and 19.7% disagreed (p =0.074).

A as high as 70% of fourth year students agreed that all students knew the limitations of clinical teaching and learning process, 13.3% were neutral and 16.7% disagreed. Whereas with the third year students (69.4%) agreed that all students knew the limitations of clinical teaching and learning process, 5.6% were neutral and 25% disagreed and 69.2% second year students agreed on the above statement, 12.3% were neutral and 18.5% disagreed (p =0.042).

All the respondents answered this item and 60% of the fourth year students agreed that remedial plan was implemented when they were not competent in a certain skill, 16.7% were unsure and 23.3% disagreed, 88.9% of third year students agreed that remedial plan was implemented when they were not competent in a certain skill, 2.8% were unsure and 8.3% disagreed and second year students had 83.3% agreeing that remedial plan was implemented when they were not competent in a certain skill, 3% of the students were unsure and 13.6% disagreed (p =0.000).

More than half (66.7%) of fourth year students agreed that they benefitted from clinical accompaniment when allocated in different clinical facilities, 6.7% were unsure and 26.7% disagreed. Third year students had 77.8% students agreeing that they benefitted from clinical accompaniment when allocated in different clinical facilities, 2.8% were unsure and 19.4% disagreed and 83.3% of second year students agreed, 4.5% were unsure and 12.1% disagreed that they benefitted from clinical accompaniment when allocated in different clinical facilities (p =0 .006).

All the respondents answered this item and 40% of fourth year students agreed that student clinical accompaniment should only be done by clinical facilitators, 6.7% were unsure and 53.3% disagreed, third year students had 72.2% agreeing that student clinical accompaniment should only be done by clinical facilitators, 8.3% were unsure and 19.4% disagreed and 63.6% of second year students agreed, 7.6% were unsure and 28.8% disagreed that student clinical accompaniment should only be done by clinical facilitators (p=0.000).

Fourth year students 43% agreed that lecturers should not be involved in clinical accompaniment of students, 10% were unsure but 46.7% disagreed. Whereas 47.2% of third year students agreed that that lecturers should not be involved in clinical accompaniment of students, 19.4% were unsure and 33.3% disagreed; and 39.4% of second year students agreed that lecturers should not be involved in clinical accompaniment of students, 18.2% were unsure and 42.4% disagreed (p=0.029).

All students answered this item and 40% of the fourth year students agreed that lecturers are involved in student clinical facilitation and accompaniment, 3.3% were unsure and 56.7% disagreed, 50% third year students agreed that lecturers are involved in student clinical facilitation and accompaniment, 8.3% were unsure and 41.7% disagreed and second year students had 66.7% agreeing, 12.1% unsure and 21.2% disagreeing that lecturers are involved in student clinical facilitation and accompaniment (p=0.000).

The average score representation for Clinical Teaching and Learning (Section C) is represented in Figure 9.

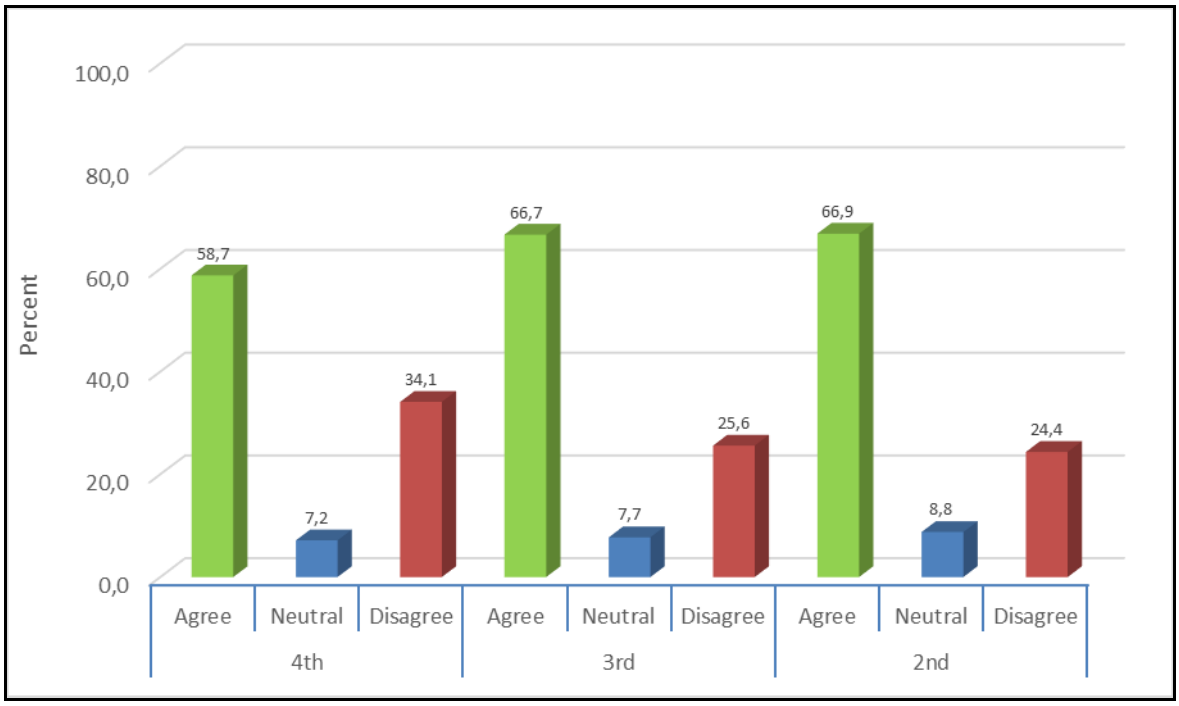


Figure 9: The average overall score for Section C of the students' questionnaire

The illustration in figure 9 indicates that generally more of the second (66.9%) and third level students (66.7%) were in agreement with most statements compared to the fourth year level students. It is also noted that 58.7% of the fourth year level students agreed with most statements in section C and 34.1% of the fourth year level students disagreed with most statements in section C.

4.3.2.1.3 SECTION D: Clinical assessments

A summary of the scoring patterns of the respondents on clinical assessment is represented in Table 10.

Table 10: A summary of the scoring patterns of the respondents on Clinical assessments in Section D

		4th			3rd			2nd		
		Agree	Neutral	Disagree	Agree	Neutral	Disagree	Agree	Neutral	Disagree
As a student I am informed of the specific criteria and standards for each clinical placement against which I will be assessed	D27	51.7	6.9	41.4	88.6	2.9	8.6	83.1	6.2	10.8
All students sign an assessment contract before being assessed	D28	73.3	0.0	26.7	91.4	2.9	5.7	82.5	4.8	12.7
We are informed in time before clinical assessments starts	D29	90.0	0.0	10.0	88.6	2.9	8.6	84.4	4.7	10.9
I avail myself for clinical practice before I am assessed	D30	80.0	3.3	16.7	97.1	0.0	2.9	90.5	0.0	9.5
We are informed in time of the skills we will be assessed on	D31	80.0	0.0	20.0	94.3	2.9	2.9	89.1	1.6	9.4
The assessment tools facilitate the integration of theory and practice	D32	76.7	0.0	23.3	97.1	2.9	0.0	84.1	6.3	9.5
There is confidentiality of the assessment outcome for each student	D33	73.3	3.3	23.3	91.4	5.7	2.9	81.3	1.6	17.2
Student and the facilitator discuss and evaluate performance against each competency thereby identifying areas of strength and areas needing improvement	D34	70.0	3.3	26.7	52.8	2.8	44.4	84.1	4.8	11.1

There were 8 questions on section D of the students' questionnaire (Table 10) and the analysis demonstrated the following:

All students answered this item and 51.7% fourth year students agreed that as students they were informed of the specific criteria and standards for each clinical placement against which they were to be assessed on, 6.9% were unsure and 41.4% disagreed with this statement. A high percentage of the third year students (88.6%) agreed that as students they were informed of the specific criteria and standards for each clinical placement against which they were to be assessed on,

2.9% were unsure and 8.6% disagreed and 83.1% of second year students agreed, 6.2% were unsure and 10.8% disagreed that as students they were informed of the specific criteria and standards for each clinical placement against which they were to be assessed on (p = 0.001).

All the respondents answered this item and 73.3% of the fourth year students agreed that all students signed an assessment contract before being assessed and 26.7% disagreed; 91.4% of third year students also agreed, 2.9% were neutral and 5.7% disagreed that all students signed an assessment contract before being assessed. With regard to the second year students, 82.5% of them agreed that all students signed an assessment contract before being assessed, 4.8% were neutral and 12.7% disagreed (p =0.002).

Many of the fourth year students (90%) agreed that they are informed in time before clinical assessments start and 10% disagreed and 86.6% of third year students also agreed that they are informed in time before clinical assessments start, 2.9% were neutral and 8.6% disagreed. Similarly 84.4% of second year students agreed that they are informed in time before clinical assessments start, 4.7% who were neutral and 10.9% disagreed (p=0.017).

A high percentage of 80 of the fourth year students agreed that they avail themselves for clinical practice before they are assessed, 3.3% were neutral and 16.7% disagreed, the third year students also had a high percentage of 97.1 that agreed that they avail themselves for clinical practice before they are assessed and 2.9% disagreed and 90.5% second year students also agreed that they avail themselves for clinical practice before they are assessed and only 9.5% disagreed with this statement (p=0.037).

Regarding skills to be assessed, 80% of fourth year students agreed that they are informed in time of the skills they will be assessed on and 20% disagreed. Similarly 94.3% of third year students agreed that they are informed in time of the skills they will be assessed, 2.9% were neutral and another 2.9% disagreed and 89.1% second year students also agreed that they are informed in time of the skills they will be assessed, 1.6% were neutral and 9.4% disagreed (p= 0.143).

Fourth year students, 76.7% agreed that the assessment tools facilitate the integration of theory and practice and 23.3% disagreed and 97.1% of third year students also agreed that the assessment tools facilitate the integration of theory and practice, and 2.9% were neutral. Similarly, 84.1% of second year students agreed, 6.3% neutral and 9.5% disagreed that the assessment tools facilitate the integration of theory and practice (p=0.000).

Out of all the students who answered this item, 73.3% of fourth year students agreed that there was confidentiality of the assessment outcome for each student, 3.3% were neutral and 23.3% disagreed and 91.4% third year students also agreed that there was confidentiality of the assessment outcome for each student, 5.7% were neutral and 2.9% disagreed. Also 81.3% second year students agreed, 1.6% were neutral and 17.2% disagreed that there was confidentiality of the assessment outcome for each student (p= 0.111).

Many of the fourth year students 70% agreed that students and the facilitator discuss and evaluate performance against each competency thereby identifying areas of strength and areas needing improvement, 3.3% were neutral and 26.7% disagreed, and 52.8% of third year students agreed that students and the facilitator discuss and evaluate performance against each competency thereby identifying areas of strength and areas needing improvement, 2.8% were neutral and 44.4% disagreed and 84.1% of second year students agreed on this statement, 4.8% were neutral and 11.1% disagreed (p= 0.033).

The average scores for clinical assessments (Section D) are shown in Figure 10.

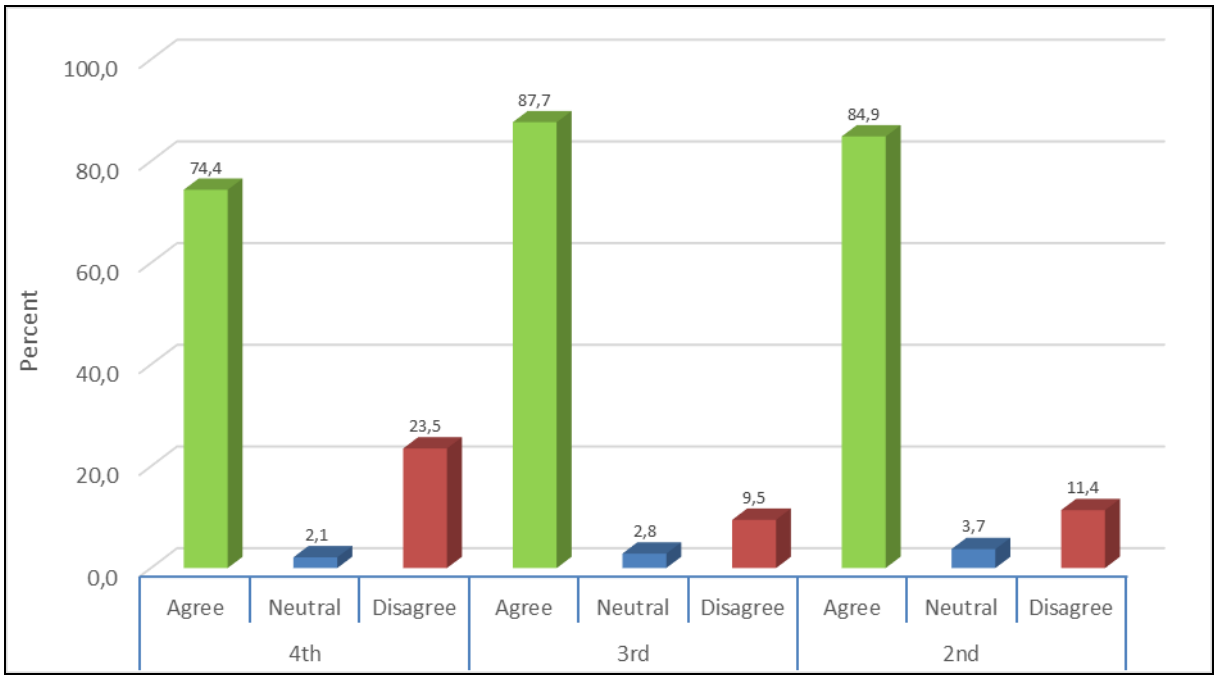


Figure 10: The average overall score for clinical assessments (Section D)

The illustration in Figure 10 shows the average overall score for Section D indicates that more of the third level students (87.7%) were in agreement with most statements compared to the second and fourth year level students. It was also noted that 74.4% of the fourth year level students agreed with most statements in Section D and 23.5% of the fourth year level students disagreed with most statements in Section D.

4.3.2.2 Lecturers

4.3.2.2.1 SECTION B: Clinical placement area

There were 13 questions on section B of the lecturers' questionnaire (Table 11) and the analysis shows that all the lecturers (100%) fully agreed that placement dates are pre-published before the placement of students to the clinical facilities.

Table 11: The responses of the lecturers to statements on clinical placement area

Section B: Clinical Placement area		Agree	Neutral	Disagree
Placement dates are pre-published before the placement of students to the clinical facilities.	B1	100.0	0.0	0.0
Students get enough clinical exposure in the clinical placements	B2	57.1	28.6	14.3
There is enough clinical accompaniments by clinical instructors in the placement area.	B3	71.4	28.6	0.0
There is an effective communication between clinical facilitators and staff in the clinical facilities re- learning outcomes.	B4	71.4	28.6	0.0
Students and clinical facilitators have effective communication regarding expectations during clinical placements.	B5	71.4	28.6	0.0
Students and clinical facilitators have effective communication re-expectations during clinical placement.	B6	85.7	14.3	0.0
As a lecturer I also visit the clinical area for accompaniment of students.	B7	100.0	0.0	0.0
The learning needs of students are clarified to the students.	B8	71.4	28.6	0.0
There is a joint responsibility between the lecturers and the clinical staff to develop the student nurses.	B9	85.7	14.3	0.0
The development and teaching of the student nurses is only the responsibility of the university.	B10	57.1	0.0	42.9
The clinical facilities are supportive of professional growth, skills development and practice of students.	B11	28.6	28.6	42.9
There is a good relationship between clinical facilitators and the clinical staff in clinical placements.	B12	100.0	0.0	0.0
There are enough clinical placement facilities to place students for clinical practice.	B13	42.9	42.9	14.3

More than half of the lecturers (57.1%) agreed that students get enough clinical exposure in the clinical placements whereas 28.6% lecturers were neutral about it and 14.3% disagreed that students get enough clinical exposure in the clinical placements.

All the lecturers answered this item and 71.4% lecturers agreed that there was enough clinical accompaniments by clinical instructors in the placement area, 28.6% were neutral, no one disagreed with the statement, similarly 71.4% of lecturers agreed that there was an effective communication between clinical facilitators and staff in the clinical facilities re- learning outcomes and only 28.6% of lecturers were neutral.

Most lecturers 71.4% agreed that students and clinical facilitators had effective communication regarding expectations during clinical placements, and the other 28.6% were neutral about this. Most 85.7% agreed that students and clinical

facilitators had effective communication regarding expectations during clinical placement and 14.3% were neutral about this.

All lecturers (100%) agreed that they also visit the clinical area for accompaniment of students and 71.4% lecturers agreed that the learning needs of students were clarified to the students but 28.6%were neutral about it. As many as 85.7% lecturers agreed that there is a joint responsibility between the lecturers and the clinical staff to develop the student nurses, and 14.3% were neutral. More than half lecturers 57.1% agreed that the development and teaching of the student nurses is only the responsibility of the university but 42.9% totally disagreed.

As little as 28.6% lecturers agreed that the clinical facilities are supportive of professional growth, skills development and practice of students, 28.6% of lecturers were neutral and 42.9% disagreed that the clinical facilities were supportive of professional growth, skills development and practice of students and 100% lecturers agreed that there is a good relationship between clinical facilitators and the clinical staff in clinical placements, and only 42.9% agreed that there were enough clinical placement facilities to place students for clinical practice and 42.9% were neutral about this, and 14.3% disagreed that there are enough clinical placement facilities to place students for clinical practice.

Figure 11 shows that lecturers were in agreement with most statements in Section B, however, 42.9% disagreed with the statements that the development and teaching of the student nurses is only the responsibility of the university (Figure 11 B10) as well as clinical facilities are supportive of professional growth, skills development and practice of students (Figure 11 B11).

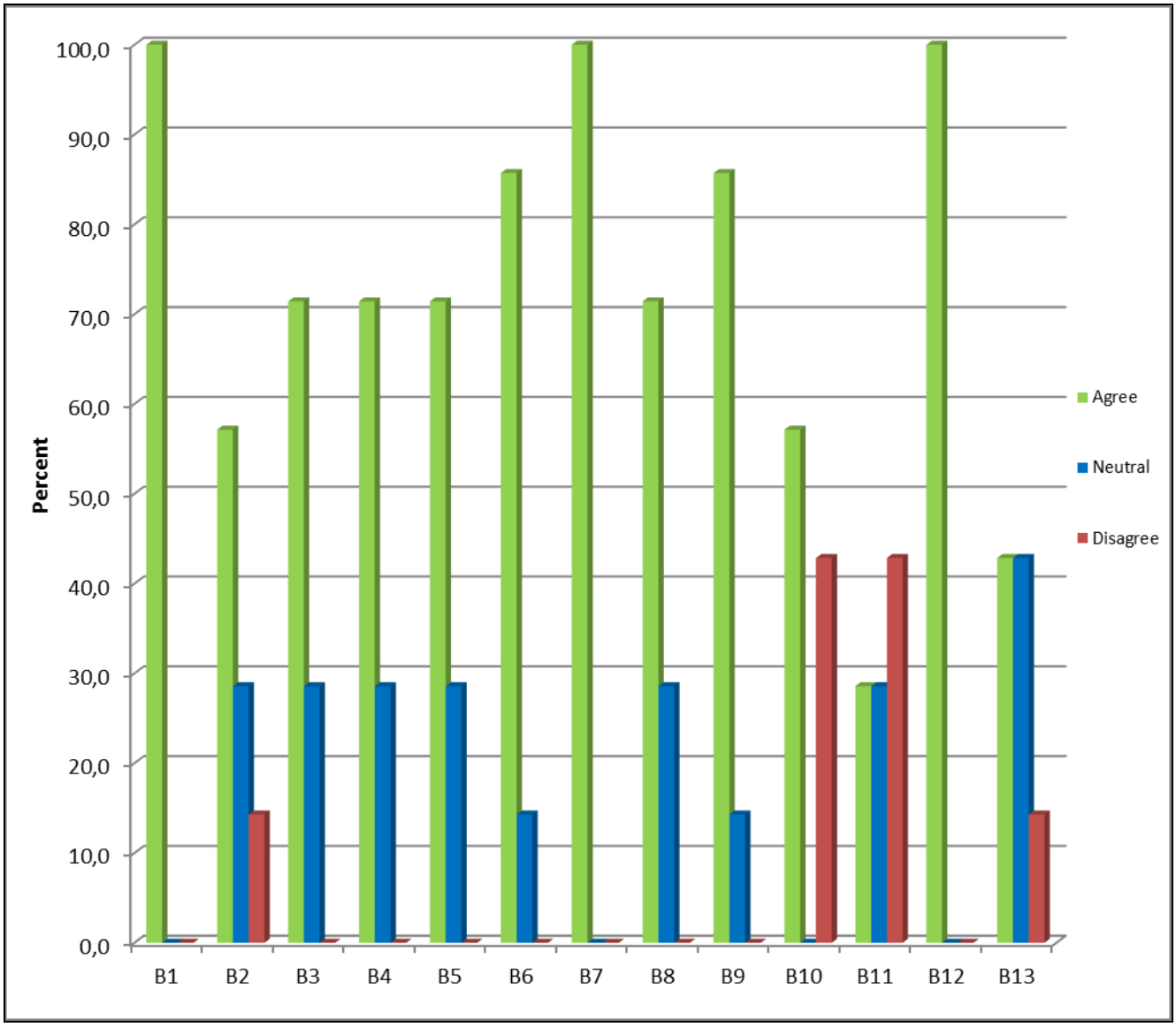


Figure 11: The responses of the lecturers to statements on clinical placement area

4.3.2.2.2 SECTION C: Clinical teaching and learning

There were 10 questions on section C of the lecturers' questionnaire (Table 12) and the analysis shows that no one agreed that the university has enough space for clinical teaching and learning activities, 28.6% were neutral about it, and 71.4% lecturers disagreed.

Table 12: The responses of the lecturers to clinical teaching and learning

Section C: Clinical teaching and learning		Agree	Neutral	Disagree
The university has enough space for clinical teaching and learning activities.	C14	0.0	28.6	71.4
The university has enough equipment and material resources for demonstration and feedback of clinical skills.	C15	50.0	16.7	33.3
The clinical placement areas have enough equipment and material resources for demonstration and feedback of clinical skills.	C16	42.9	42.9	14.3
Students are theoretically prepared before they are sent to clinical facilities.	C17	71.4	14.3	14.3
Nursing students are willing to learn.	C18	100.0	0.0	0.0
Students accept constructive criticism.	C19	71.4	28.6	0.0
All students know the limitations of clinical teaching and learning process	C20	71.4	14.3	14.3
Remedial plan is implemented if there is a student fails to master the skill.	C21	83.3	16.7	0.0
Clinical facilitators get full support from the lecturers.	C22	66.7	33.3	0.0
Clinical accompaniment does benefit students.	C23	100.0	0.0	0.0

Half of the lecturers (50%) agreed that the university has enough equipment and material resources for demonstration and feedback of clinical skills, 16.7% were neutral and the other 33.3% disagreed that the university had enough equipment and material resources for demonstration and feedback of clinical skills.

A low percentage of 42.9 agreed that the clinical placement areas had enough equipment and material resources for demonstration and feedback of clinical skills, 42.9% were neutral, 14.3% disagree, and 71.4% agreed that students were theoretically prepared before they are sent to clinical facilities, 14.3% were neutral and another 14.3% disagreed. All the lecturers 100% agreed that nursing students were willing to learn, 71.4% of lecturers agreed that students accepted constructive criticism, but 28.6% were neutral about it.

All the lecturers answered this item and 71.4% agreed that all students knew the limitations of clinical teaching and learning process, 14.3% were neutral and another 14.3% disagreed with this. Most of the participants (83.3%) agreed that remedial plan is implemented if a student fails to master the skill, but 16.7% disagreed; 66.7% agreed that clinical facilitators get full support from the lecturers and the other 33.3%

were neutral. Lastly all lecturers (100%) agreed that clinical accompaniment does benefit students.

Figure 12 shows that lecturers were in agreement with most statements in Section C, however, 71.4% disagreed with the statement that the university has enough space for clinical teaching and learning activities (Figure 12 C14).

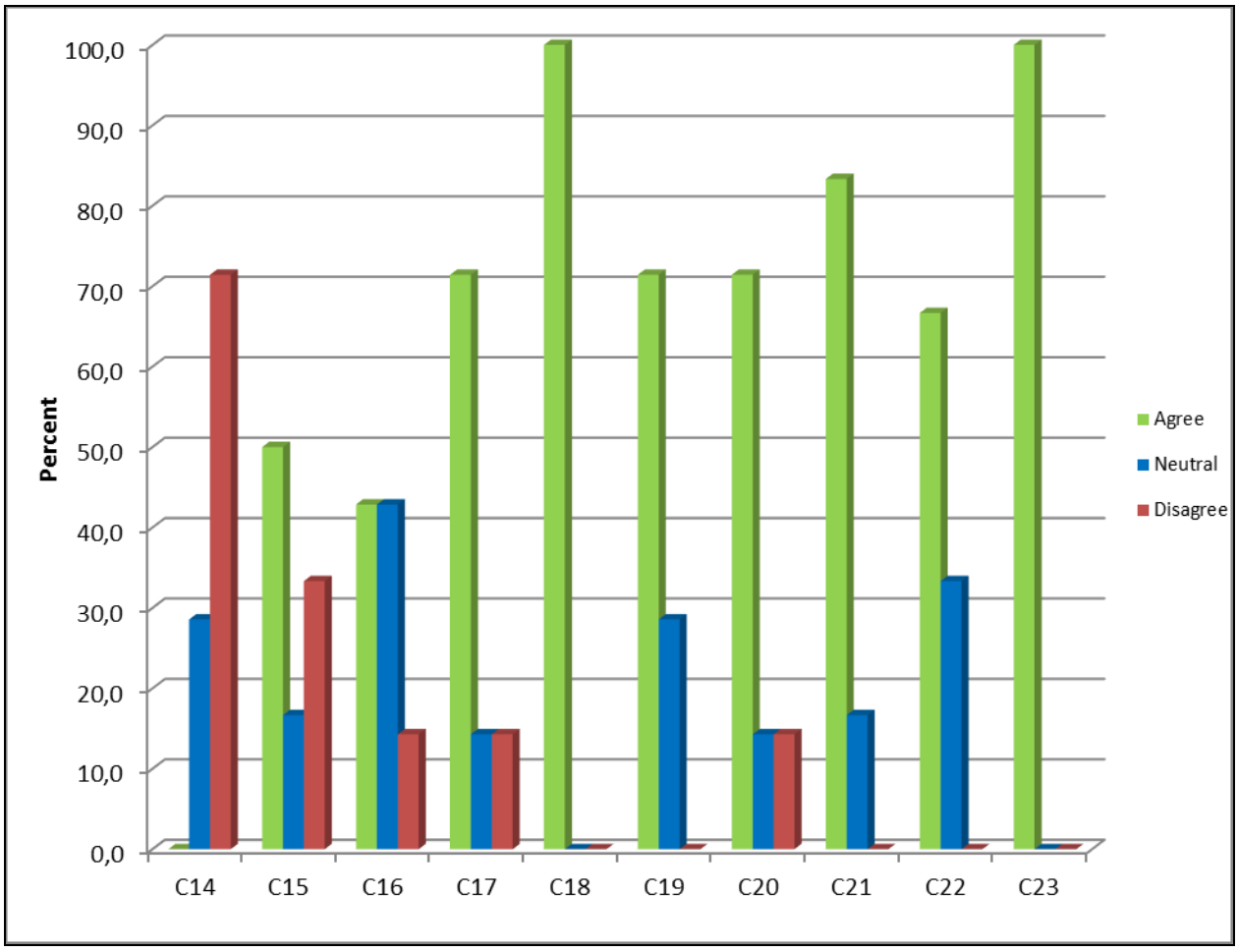


Figure 12 shows the responses of the lecturers to statements on clinical teaching and learning

4.3.2.2.3 SECTION D: Clinical assessments

The responses of the lecturers on clinical assessment are represented in Table 13.

Table 13: The responses of the lecturers on clinical assessments

SECTION D: Clinical assessment		Agree	Neutral	Disagree
Students are informed of the specific criteria and standards for each clinical placement against which they will be assessed.	D24	71.4	28.6	0.0
All students sign an assessment contract before being assessed.	D25	85.7	14.3	0.0
Students are informed in time before clinical assessments starts.	D26	85.7	14.3	0.0
Students avail themselves for clinical practice before they are assessed.	D27	57.1	42.9	0.0
The assessment tools facilitate the integration of theory and practice.	D28	85.7	14.3	0.0
There is confidentiality of the assessment outcome for each student.	D29	100.0	0.0	0.0
Student and the facilitator discuss and evaluate performance against each competency thereby identifying areas of strength and areas needing improvement.	D30	57.1	42.9	0.0
Lecturers have an input in the development of assessment tools.	D31	57.1	42.9	0.0
As lecturers we are involved in clinical assessments of students.	D32	57.1	28.6	14.3

There were 9 questions on section D of the lecturers' questionnaire (Table 13) and the analysis shows that 71.4 % of participants agreed that students are informed of the specific criteria and standards for each clinical placement against which they will be assessed and 28.6% were neutral; 85.7% agreed that all students signed an assessment contract before being assessed, 14.3% were neutral; 85.7% agreed that students are informed in time before clinical assessments starts and 14.3% were neutral; 57.1% agreed that students availed themselves for clinical practice before they are assessed and 42.9% were neutral; 85.7% agreed that the assessment tools facilitate the integration of theory and practice and 14.3% were neutral; 100% of participants agreed that there was confidentiality of the assessment outcome for each student. More than half (57.1%) agreed that the student and the facilitator discussed and evaluated performance against each competency thereby identifying areas of strength and areas needing improvement, 42.9% were neutral; 57.1% agreed that lecturers have an input in the development of assessment tools but

42.9% were neutral; 57.1% that as lecturers they were involved in clinical assessments of students, 28.6% were neutral and 14.3% disagreed.

Figure 13 summarises the lecturers' responses to statements on clinical assessment.

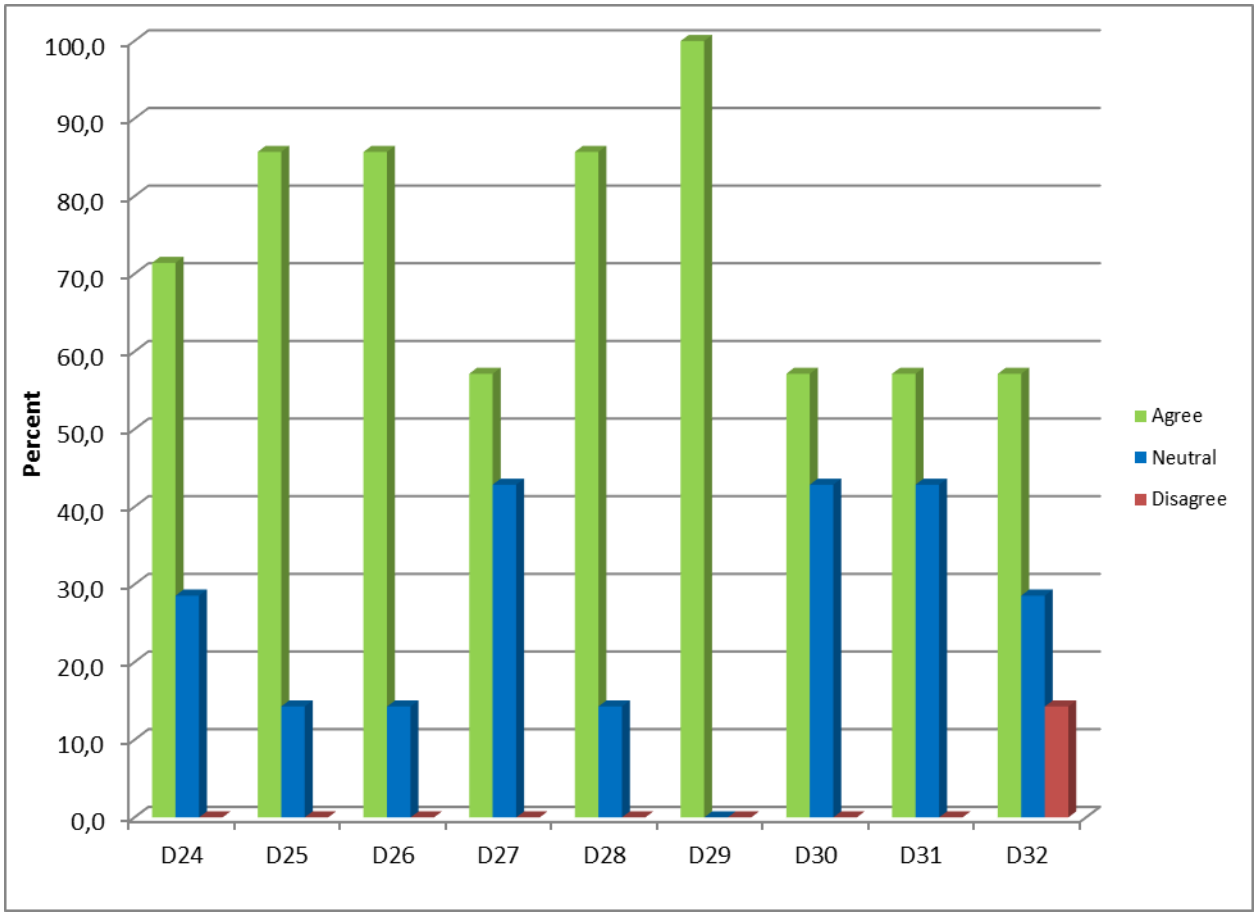


Figure 13: The responses of the lecturers to statements on clinical assessments

Figure 13 illustrates that most lecturers were generally in agreement with the statements in Section D, noting that only 14.3% were in disagreement with the statement that lecturers were involved in clinical assessments of students (Figure 13 D32

4.3.2.3 Comparison of students and lecturers perceptions

A Mann Whitney test was used to compare between students and lecturers perceptions when the dependent variable is either ordinal or continuous since the

statements in both their questionnaires were the same (Appendix 6(a) and 6(b)). The results are indicated in Table 14.

Table 14: The comparison of perceptions between students and lecturers

	Mann-Whitney U	Asymp. Sig. (2-tailed)
Placement dates are pre-published before the placement of students to the clinical facilities	393.500	.560
I get enough clinical exposure in the clinical placements	350.000	.309
There is enough clinical accompaniment by clinical instructors when we are in the placement area	412.000	.708
Students and clinical facilitators have effective communication re-learning outcomes	387.000	.527
There is an effective communication between clinical facilitators and staff in the clinical facilities re- learning outcomes	272.500	.072
We as students and clinical facilitators have effective communication re- expectations during clinical placements	310.000	.143
There is effective communication between clinical facilitators and clinical staff re- expectations during clinical placement	247.500	.036
The learning needs of students are clarified to us as students	405.500	.659
The clinical facilities are supportive of professional growth, skills development and practice of students.	223.000	.016
There are enough clinical placement facilities to place students for clinical practice	339.000	.268
The university has enough space for clinical teaching and learning activities	158.500	.003
The university has enough equipment and material resources for demonstration and feedback of clinical skills	384.500	.517
The clinical placement areas have enough equipment and material resources for demonstration and feedback of clinical skills	354.000	.711
We are theoretically prepared before we go for clinical facilitation.	289.000	.095
As a nursing student I am willing to learn	295.000	.294
Students accept constructive criticism	350.500	.360
All students know the limitations of clinical teaching and learning process	364.500	.385
Remedial plan is implemented when we as students are not yet competent in a certain skill.	365.000	.801
As a student I benefit from clinical accompaniment when allocated in different clinical facilities.	425.500	.782
Student clinical accompaniment should only be done by clinical facilitators.	317.500	.169
Lecturers are involved in student clinical facilitation and accompaniment.	421.000	.757
As a student I am informed of the specific criteria and standards for each clinical placement against which I will be assessed	382.000	.523
All students sign an assessment contract before being assessed	304.500	.138
We are informed in time before clinical assessments starts	231.000	.019
I avail myself for clinical practice before I am assessed	219.500	.012
The assessment tools facilitate the integration of theory and practice	368.500	.443
There is confidentiality of the assessment outcome for each student	362.000	.849
Student and the facilitator discuss and evaluate performance against each competency thereby identifying areas of strength and areas needing improvement	324.500	.216

All the highlighted significant values and statements with p-values < 0.05 in Table 14 imply that students and lecturers had different opinions on those statements in their questionnaires. The rest of the statements with p values >0.005 indicate that the opinions were more or less the same for both the students and the lecturers. These values are discussed in the statements below:

a) The p-value for the statement "effective communication between clinical facilitators and clinical staff regarding expectations during clinical placement" was 0.036. There were 71.4% of the lecturers who agreed with this statement, 40.1% fourth year students, 61.1% third years and 66.2% second year students agreed with this statement. This shows that there was disagreement between the fourth year level students and the lecturers. This could be due to the fact that the lecturers do not often go for clinical accompaniment so they are not sure of what is happening in the facilities as opposed to the fourth year students have been in the programme for a longer period.

b) The p-value for the statement "clinical facilities are supportive of professional growth, skills development and practice of students" was 0.016. As little as 28.6% lecturers agreed with the statement, whereas 63.3% of the fourth year students, 75.0% of third year students and 81.1% of second year students felt there is support in the facilities. This could mean that lecturers do not get feedback from the students when they are back from clinical facilities since they do not do clinical accompaniment.

c) The p-value for the statement "university has enough space for clinical teaching and learning activities" was 0.003. None of the lecturers agreed that there is enough space for clinical teaching and learning activities in the university. A few fourth year students (23.2%), on the other hand, felt there was enough space. Whereas, 41.7% third year students and 29.7% second year students also felt there is enough space. This could mean the students feel that the clinical instructors are doing a good job since they improvise and make sure that the students always have clinical education and facilitation even if it takes place in the classroom.

d) The p-value for the statement “we are informed in time before clinical assessments starts” was 0.019. All lecturers and the majority of the students were in agreement with this statement. However, 10,0% of fourth year students, 8.6% third year students and 10.9% second year students disagreed with this, This shows that some students are sometimes not ready for their clinical assessments when they are assessed.

e) The p-value for the statement “I avail myself for clinical practice before I am assessed” was 0.012. A positive response was received from only 57.1% of the lecturers compared to the majority of students (80% fourth year students, 97.1% third year students and 90.5% second year students) agreed with the statement. This showed that the lecturers do not really involve themselves in clinical facilitation which made some of them disagree that the students avail themselves for clinical practice before its assessment.

Therefore, the responses to the statements from the questionnaires indicate that lecturers and students had generally the same viewpoints concerning clinical facilitation except for the few statements that were different, which are highlighted in table 15.

4.4 PRESENTATION OF QUALITATIVE DATA

4.4.1 INTRODUCTION

A total of 8 clinical instructors were recruited for qualitative data collection. One clinical instructor participated in the pilot study and the rest (n = 7) were in two focus group discussions which were done in two different days. The clinical instructors had experience and were directly involved with clinical facilitation. A validated interview guide was used to interview the clinical instructors on their perceptions of clinical facilitation (appendix 7). There were three main areas which were asked and had sub-questions. The questions were on the roles and experiences of the clinical instructors during clinical facilitation and the benefits of clinical accompaniment to the students.

4.4.2 STATEMENT OF FINDINGS, INTERPRETATION AND DISCUSSION OF THE QUANTITATIVE PRIMARY DATA

The results and discussion of the findings obtained from the focus group discussions in this study will be presented in this section. The data collected from the responses using a Dictaphone as well as by taking notes during the interview were transcribed and thereafter analysed. The results will be presented in the form of themes and sub-themes.

4.4.3 PRESENTATION OF QUALITATIVE DATA

Table 15 indicates a sample of the focus group discussions that were held. The interviewer would read a question from the guide and wait for the responses from the participants with further clarification when required. Moving from one question to the next was done when the participants would no longer venture any more responses to the questions or when they would repeat what they had mentioned previously, which is data saturation.

Table 15: Questions and responses of the focus group discussions

QUESTIONS	RESPONSES: focus group 1	RESPONSES: focus group 2
1. What does clinical facilitation mean to you?	Respondent 1: "To me it means a relationship between the students, clinical facilities and clinical facilitators".	Respondent 1: "I think it is making clinical teaching as enjoyable as possible for the students".
	Respondent 2: "Clinical facilitation is ensuring that the students receive enough support and guidance during their practical's".	Respondent 2: "It is the support of students in order to master their skills and gain confidence".
	Respondent 3:"To me it means working together with the students for guidance and support, and this helps in correlation of theory and practice".	Respondent 3: Did not respond
	Respondent 4: Did not respond.	
When the respondents kept quiet the interviewer moved to the next question		
2. Do you receive enough support as a clinical instructor by management and other colleagues? If not how would you like them to support you?	Respondent 1: "Hey I don't know what to say, but I don't think they are doing enough for us since we still do not have enough transport for accompaniment".	Respondent 1: "I feel they are not supporting us but they are expecting wonders from us. There are many students and increasing numbers yearly but no new facilities".
	Respondent 2: "If it is not for clinical team work and support I don't know where we would be, because the clinical department is not	Respondent 2: "We have asked for workshops specific to clinical staff for several times but nothing has happened so we

	seen as part of the nursing department as they are deprived of other important things like e-learning".	are working through trial and error".
	Respondent 3: "There are no incentives in this place after so much hard work with such few staff and so many students".	Respondent 3: "We want to carry this department forward but we are tired no one wants to listen to us".
	Respondent 4: "Our student numbers are very high and increased yearly with very few facilities at this university that is hard on us".	
When the respondents kept quiet the interviewer moved to the next question		
3. Are there any restrictions during accompaniment of students? If there are please explain.	Respondent 1: "Yes we do one has been mentioned which is far facilities and it is tiring I am telling you, you get tired before you do anything because of travelling".	Respondent 1: "It is hard to do accompaniment for us because we are short staffed and most lecturers are not doing any accompaniment, they do not think it's their duty".
	Respondent 2: "The other problem is that our students disappear because they are not sure if they know what they are doing and they do not think that us being there will assist".	Respondent 2: "So far I don't think there are many problems but the restriction I see is time and far facilities".

	Respondent 3: “My worry is our students are not receiving quality since the clinical instructor: ratio too much something should be done”.	Respondent 3:
	Respondent 4: “It would be nice if we get more transport and more staff as well as more facilities”.	
When the respondents kept quiet the interviewer moved to the next question		

During the transcription of data collected the researcher played the tapes (focus group discussions 1 and 2) over and over comparing with the written notes taken during the interview. Themes and sub-themes were identified from the responses to establish patterns emerging and data was interpreted manually. By reading the excerpts, this led to keywords and processes which resulted in themes and sub-themes. Data was then analysed under the following eight themes:

Theme 1: Management support
Theme 2: Staff shortage
Theme 3: Clinical staff development
Theme 4: Distant clinical facilities
Theme 5: Too many expectations by clinical facilities
Theme 6: Challenges faced by students in the clinical area
Theme 7: Clinical programme drawn early
Theme 8: Employing Mentors

Table 16 shows themes and sub-themes that emerged during the focus group interviews. Applicable direct quotes are provided to substantiate relevant results. The results of this study are presented along the themes and sub-themes that were derived from the analysis of the focus group interview.

Table 16: Overview of themes and sub-themes that emerged during focus group interview

THEMES	SUB-THEMES
1. Lack of management support	• Finding more clinical facilities for students allocation • Not enough clinical skills laboratories
2. Staff shortage	• Clinical facilitator : student ratio • Hiring more clinical facilitators
3. Clinical staff development	• Induction • Proper orientation • Workshops specific to clinical facilitation
4. Distant and not enough clinical facilities	• Tiring for staff and students • Not enough student support • There is not enough exposure for students
5. Too many expectations by clinical facilities	• Orientation of students in the wards by clinical facilitators • Having a clinical facilitator on the floor daily for the students • Building a good relationship with facilities
6. Challenges faced by students in the clinical area	• Lack of resources in clinical facilities • Re-look at university policies • Finding the cause
7. Clinical programme drawn early	• Early submission of the clinical programme to clinical placement • Making allocation early • Off duties sent to the facilities in time
8. Employing Mentors	• For good collaboration with clinical placements • For continuous student support

4.5 PRESENTATION OF THEMES AND SUB-THEMES

The themes and sub-themes that emerged from the responses are summarised below with applicable direct quotes to substantiate relevant results.

4.5.1 Lack of management support

The participants reported that there was support amongst clinical staff which was what kept them going but there seemed to be lack of support from the university management as the respondents were still worried about shortage of clinical placements although the course was in its fourth year. This was supported by the following statements:

"…from the clinical colleagues, yes there is support that is what keeps us going because of team work and the support that we have for each other, the management needs to try and try harder to find clinical placement of our students even if it means communicating with South African Nursing Council".

"We will say management does not support us because since the course is in the fourth year we should be having enough clinical facilities and enough clinical skills laboratories to us, they are not trying hard enough".

"…there are only two clinical laboratories to be used by four levels of students and sometimes there are clashes and we end up using classrooms for some skills which is unacceptable".

4.5.2 Staff shortage

The respondents reported that they were short staffed, looking at the large number of students. The SANC requirements for student contact are at least 30 minutes per student and the respondents felt this was impossible. Clinical facilitator: student ratio was also a concern which made the respondents feel the need of hiring more staff in order to produce competent clinical practitioners. This challenges experienced by the participants are reflected in the excerpts below:

"…I feel one of the distractions in clinical facilitation is the clinical facilitator ratio during student accompaniment whereby the clinical facilitator has to accompany a large number of students in one facility in one day. And you find that you start the day by driving about two hours to a facility and you have to drive another two hours back".

"….for me I think if we want to produce competent and safe practitioners our management need to think of recruiting more clinical facilitators looking at the number of students per level and looking at the clinical facilitator: student ratio, it is too much".

"…looking at the number of students versus the number of clinical facilitators, sometimes accompaniment does not benefit all students as not all students are given enough time during contact due to short staffing and far facilities".

"...management should consider employing more clinical staff, reduce the number of students or maybe hiring of mentors who will always be at the facilities for student support and addressing other issues from clinical facilities and to produce competent and safe practitioners".

"…It is also important that the lecturers work hand in hand with the clinical facilitators for the students to see the importance of correlating theory and practice".

4.5.3 Clinical staff development

Induction and orientation of staff is crucial in all organizations for the best staff performance. However, in this study, the participants reported that there was no specific induction and orientation for clinical facilitators. This is evident in the following participants' voice:

"Up to this point there has never been a specific induction on clinical facilitation process since people are from different backgrounds and there are new things that should be learnt and lots of expectations and to assist in producing competent practitioners everyone has to find her feet by trial and error".

"I think we also need workshops on how to further develop clinical facilitators so as to be consistent in what we are doing, formulating clinical guidelines and assessments".

4.5.4 Distant and not enough clinical facilities

Placement facilities that are far were another concern for the respondents as they felt that the management needed to try harder in finding more local facilities since even students were affected by this. They indicated that more facilities that are close should be secured. Many clinical facilitators had the following to say regarding this issue:

> *"...regarding the clinical facilities I feel the management need to put more effort in finding facilities which are close to the campus, that will help even in close monitoring our students and it will give us more time with students during accompaniment".*

> *"…again with these far clinical facilities as we have mentioned before they leave us tired before we even start working and not giving enough time to our students, so finding more closer facilities or hiring mentors/ preceptors to assist will help".*

> *"Students are also affected by this since, they need money to buy food and some parents are unemployed whereas if they are allocated close by there will be no need to worry parents with money".*

The respondents were concerned about driving far which is challenging and exhausting, besides that they reported that it exposes them to risks such as road accidents, thus exposing them to stress and anxiety which might affect their performance during student accompaniment. They were also worried about students on night duty not being accompanied. Statements below explain better:

> *"…far clinical facilities whereby you drive a long distance the moment you reach the facility you are already tired and obviously you won't see all the students if you do proper accompaniment and you keep checking the time because you have to drive back. At least if three people can go to far facilities so that all students are seen and we can work with them properly but it is impossible with limited staff".*

"…with so much accidents reported on the roads it is now scary to drive far, it is stressing not knowing whether one will reach the facilities or not which also affects my performance because I also need to think of travelling back to the campus"

"…the other challenge is not being able to accompany students on night duty so if more staff can be hired it would be easier to work and also have beds and breakfast paid for, so as to sleep over and have enough time with the students".

The other concern expressed about facilities was that they were not enough which causes problems when all 400 students needed to be allocated at the same time. Clinical facilities are approved by SANC and they have a stipulated number that they can take at a given time, which is a problem sometimes because the number of students is too large compared to the facilities and numbers that they can accommodate according to SANC requirement. Furthermore, most of the facilities are at a district level and the respondents were worried that students were not receiving enough exposure. Therefore, more local university hospitals should be secured for the sake of the students. Some respondents made the following comments:

"…no learning opportunities since most of the facilities we are using are at district level, for complicated cases patients are referred to university hospitals where our students are not allocated. Our students end up not receiving enough learning opportunities so it would be great if we get the university hospitals which would match students learning needs".

"…if we can be given local facilities it can even be easy for us to monitor student absenteeism and our students can use clinical skills laboratories more for practice after work which will boost their confidence".

4.5.5 Too many expectations by clinical facilities

The respondents had concerns about some of the expectations by some departments in the clinical facilities. They felt that there were discrepancies and impossible expectations as they were supposed to work as a team in supporting students. Some of these expectations are explained below:

> *"…my problem is that some facilities have certain expectations from us which sometimes are a discrepancy and they are really impossible, like wanting us to be at the facilities every day for our students because they are short staffed and they cannot take care of our students".*

> *"I do not understand the fact that each time our students are placed a clinical facilitator we should always be there with the students, we have been doing this for three years, and really something should be done about this".*

> *"It is even worse when we are asked to orientate students in their wards, how is that our responsibility? But we do it for the sake of our students and the relationship we have with them but it is wrong".*

4.5.6 Challenges faced by students in the clinical area

It is the duty of both the training institution and the clinical facilities to make sure that students get enough support during their stay in the facilities. This can only happen if there is a good relationship between these two facilities. The respondents felt that there was still a lack of this relationship in some facilities where they are allocating students to, and this poses lots of problems for the students as well. Some feedback received is as follows:

> *"…the problem with our students is that they are not all the same as some are from Model C schools and others are from rural schools so there is a discrepancy whereby the ones from Model C schools grasp easily because of their English understanding and the others take time so one needs to spend more time with those who take time to grasp and the others get bored,*

therefore they need someone who is patient with them, some nursing staff in the facilities do not have enough time for students as they also complain of staff shortage ".

"…staff in the facilities are busy so it is our duty to make sure there is enough student support since students need to be able to relate their problems either social or work related and sometimes it is not easy to do so with ward staff as they do not have enough time.

"…sometimes it is hard when you go to the facilities and find students doing the wrong thing and they will tell you this is how it is done because there are no resources".

4.5.7 Clinical programme drawn early

The respondents raised concern of not being organized which is one of the other things that leads to management in the clinical facilities not taken seriously. They felt it would be advisable if the clinical programme is sent to the facilities at least four months prior to placing students so that they know in advance when students will be sent to them so they are able to allocate the students appropriately.

"…organizational issues are holding us back whereby allocation and off duties are not sent to the facilities in due time and the nursing managers will fight with us".

"*Management has to try and have clinical programme drawn up at least by August for the following year and sent early to the clinical facilities that will make us organized*".

4.5.8 Employing Mentors

Clinical facilitators are expected to accompany the students in the clinical area to ensure that there is integration of theory and practice. However, due to large number of students, clinical facilities that are far and short staffing in the clinical department

the respondents felt that this was not properly done and students were deprived of support. They felt hiring Mentors in each hospital will assist in student support. This is evident in the following participants' voice:

> *"…employing of mentors will assist both the clinical facilities and the clinical department since there is minimal support from the lecturers. A mentor will be at the placement every day to attend to our students as well as the queries from the facilities"*

> *"…The other thing that may help is finding mentors or preceptors who will be at the facilities daily to attend to our students and we continue with our weekly accompaniment, I think that will benefit our students and reduce some of our frustration".*

> *"I think mentors will also assist in monitoring student absenteeism since in some institutions they cannot monitor student absenteeism whereas our students need to cover a certain number of hours to qualify as a professional nurse".*

4.6 STUDENT ACCOMPANIMENT TOOL: SUGGESTIONS

This was the last question in the lecturer's questionnaires and in the clinical instructors' interview where they were asked to suggest on what should be included in an accompaniment tool if it were to be developed, which they could easily use and also be student friendly. Lecturers wrote down their views which were common to those of the clinical facilitators. The following are excerpts of what was suggested by both clinical instructors and lecturers:

> *"…it is important that the accompaniment tool is guided by the nursing process so that the students get used to using nursing process during nursing care of all patients which includes record keeping which is one of the weak points of the nurses".*

"This tool must also check students' cognitive, psychomotor and affective skills since cognitive and psychomotor will assist in bridging the theory-practice gap and affective skills will encourage our students to communicate with their patients which seem to be a problem with our students".

"…please do not forget to include the professional part, checking of uniform and the way the students communicate with patients and with us is very important".

"…also include rationale so that the students will explain each step that they are doing which will show understanding of the procedure and scoring at the end so that they know how much they scored and how much they need to improve on that skill".

4.7 CONCLUSION

In this chapter, an analysis of the information derived from the questionnaires and interviews with the selected participants was done. Questionnaire scoring patterns were presented and statistically analysed.

The first objective assessed the facilitation of the clinical training component by ascertaining the experiences of the clinical instructors where it was found that the clinical instructors were dissatisfied with the clinical training programme in that the clinical facilities were not enough for the students and that they were far. They also felt that the UoT management does not support them by finding more clinical facilities and arranging an orientation programme for them. However, they had a good team spirit which kept them going.

The second objective assessed the facilitation of the clinical training component by ascertaining the perceptions of the lecturers where it was found that lecturers felt that student accompaniment is not their role but that of the clinical instructors. Furthermore, they did not involve themselves much on clinical facilitation as they were unsure of most clinical matters including student readiness and clinical accompaniment.

The third objective assessed the facilitation of the clinical training component by ascertaining the perceptions of the students where it was found that students had a positive attitude about clinical facilitation. They felt that the clinical instructors were doing a good job and they benefited from the clinical accompaniment conducted weekly when they are placed in clinical facilities. There were differences in student responses between the levels where a few of fourth level students felt that their learning needs are clarified to them as opposed to the majority of third and second level students feeling the same. It was noted that most of second and third level students were generally in agreement with most statements compared to the fourth level students who were more experienced with clinical facilitation.

The fourth objective was to describe the benefits of student accompaniment in the clinical facilities as perceived and experienced by the clinical instructors. The clinical instructors had mixed feelings about this. Some felt that student clinical accompaniment benefited the students and the students felt safe and confident when the clinical instructors were around. However, others felt that since clinical facilities are far, the students did not benefit maximally since they spend less time with them having to rush back home. They suggested that mentors should be employed and that lecturers should involve themselves with clinical accompaniment.

A discussion of the results follows in the next chapter. Themes that were identified from the qualitative research is also analysed in the next chapter.

CHAPTER 5

DISCUSSION AND CONCLUSION

5.1 INTRODUCTION

Clinical facilitation has the opportunity to help students grow and develop personally and professionally (Sanderson and Lea, 2012). This can be done by collaboration between training institutions and clinical placements' key players such as lecturers, clinical facilitators, ward managers, ward staff and mentors (Andrews et al., 2006).

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 study objectives, findings from the students' and lecturers' questionnaires, elements of the clinical placement education model by Andrews et al. (2006) as well as by the themes that emerged from the analysis of the focus group interview. Findings that have statistical significance is included in the discussion, which are statements with $p < 0.05$. Recommendations are suggested based on the results of the research investigation.

5.2 OVERVIEW OF RESEARCH DISCUSSION

This analysis was conducted to satisfy the objectives of this study as stated in chapter one. The four objectives of this study were:

1. To assess the facilitation of the clinical training component by ascertaining the experiences of the clinical instructors during clinical accompaniment by using a focus group interview.
2. To assess the facilitation of the clinical training component by ascertaining the perceptions of the lecturers by the use of a questionnaire.
3. To assess the facilitation of the clinical training component by ascertaining the perceptions of the students by the use of a questionnaire.
4. To describe the benefits of student accompaniment in the clinical facilities as perceived and experienced by the clinical instructors.

This study aimed at assessing the clinical training component of the undergraduate nursing programme at a UoT, based on the views of students, lecturers and clinical instructors. A quantitative survey was used with the lecturers and student nurses followed by a descriptive qualitative research using an interview guide to interview the clinical facilitators in this university. The findings from the qualitative investigation led to the eight themes discussed in this chapter. Findings from the quantitative survey were used in supporting the qualitative findings. The quantitative survey yielded perceptions from both the lecturers and students and they were in most instances the same as what had been indicated by the clinical instructors during the focus group discussions.

5.3 DISCUSSION

5.3.1 Lack of Management support

Lack of management support, as mentioned by the clinical facilitators during the focus group interview, demoralized the staff. Management support plays a very important role in any organisation. If staff feel good, they are encouraged to work harder. The clinical facilitators indicated that despite the fact that the course was in its fourth year, management had not provided sufficient local clinical facilities and clinical skills laboratories. They felt that management was not trying hard enough. The Andrews et al. (2006) clinical placement education model encourages staff support by management as this motivates staff. If this does not happen, staff feel neglected and unappreciated. Most lecturers (71.4%) felt that the university does not have enough space for clinical teaching and learning activities. This response supported the clinical instructors' view, who felt there should be more clinical laboratories but management is slacking in finding them. According to the clinical instructors, there are two clinical skills laboratories at this UoT which are shared by all four students' groups. Sometimes there are clashes between groups which lead to conflict among staff and students having an impression that clinical instructors are disorganised. The students mentioned that sometimes some of the skills are taught in class which makes simulations ineffective. This is done to give other groups a chance to utilize the skills laboratory. The clinical facilitators indicated they expected management to communicate with the South African Nursing Council regarding

clinical placements since the course was approved. Therefore, they should assist in opening space in local clinical facilities for the students. The clinical facilitators stated that “they (the clinical facilitators) supported each other and worked as a team. This is what kept them going.” Therefore, management should find out what the staff needs are and attend to them so that there is no conflict among staff and they are motivated to work even under strenuous conditions.

According to Mogale (2011), leadership in any training institution should ensure that the education and training needs of the clinical facilitators, educators and students are taken seriously throughout. The management needs to make sure that the students: clinical facilitator ratio is conducive to facilitation and learning. Large student numbers can have a negative impact on clinical facilitation, leading to disadvantaging the student (Mellish et al., 2000) cited by Mogale (2011). Lecturers had the same view as the clinical facilitators, i.e., that the management should improve the clinical skills laboratories and support clinical staff.

Notably, 50% of fourth year students disagreed with the statement that the university has enough equipment and material resources for demonstration and feedback of clinical skills. Likewise, 47.2% third year students and 43.1% second year students shared the same sentiment (p=0.214). Fourth year students had the highest percentage of disagreement and it was noted that they were the least satisfied since they had more experience as well as expectations from the UoT clinical setting. Management should consider the view point of the fourth year students as they have more experience. It is further recommended that management also attends to the clinical facilitators’ suggestions in order to produce competent professional nurses.

5.3.2 Staff shortage

Clinical instructors stated that one of the problems they faced in clinical facilitation was with the clinical facilitator: student ratio during student accompaniment, as facilitators were accompanying a large number of students in one facility in one day. This had a negative impact on students. Hlongwa (2009) found that staff shortage had a very negative impact on student support during clinical placements since students did not get enough attention and contact leading to the production of

students who were incompetent. He further reported that shortage of staff impacts on R425 diplomates' competencies. There is thus a need to apportion the available hours carefully to ensure that each student gets enough support which is not possible when there is shortage of staff. Clinical instructors highlighted that if the university wants to produce competent and safe practitioners, management should consider recruiting and employing more clinical facilitators considering the number of students per level and the clinical facilitator: student ratio which is very high. There are 8 clinical facilitators for ±390 students. In a study undertaken in Tanzania (Ayo, 2006), the lecturer/facilitator: student ratio of 1:8 was recommended, which means one clinical lecturer/facilitator per eight students.The clinical facilitators indicated that the number of students versus the number of clinical facilitators sometimes does not provide all students with sufficient contact time with the clinical facilitator during accompaniment and most students do not benefit due to shortage of staff. They further mentioned that lecturers should work hand in hand with them to support the students since there is staff shortage. Andrews et al. (2006) stated that there should be enough clinical staff in all campuses or training facilities for student support and if there is staff shortage students will suffer. Therefore, it is recommended that university management should employ more clinical staff at the UoT and mentors who will be placed in the facilities for student support. If employing more staff and mentors is a problem management should reduce the number of students' intake per year. Some of the lecturers did indicate that they were unsure whether they give clinical facilitators full support which confirmed with the clinical facilitators when they mentioned being short staffed and that very little support was provided by the lecturers. Therefore, it is recommended that this must be attended to in this UoT before damage to the course occurs, like losing more staff due to burnout.

Only 57.1% of the lecturers indicated that they are involved in clinical assessments, however, the other half were unsure or disagreed with the statement which means some do support the clinical staff but others do not. It was noted that the students stated that they benefitted from clinical accompaniment when allocated in different clinical facilities (p=0 .006) and most of them felt that clinical accompaniment should only be done by the clinical facilitators (p=0.000), at the same time some of the students in the fourth level (43.3%), third level (47.2%) and second level (39.4%) felt that lecturers should not be involved in clinical accompaniment of students

(p=0.029). It is however, recommended that lecturers partake in clinical accompaniment of students since the students will benefit from it with more staff involved, although less than 50% of the students in each level had indicated that lecturers should not be involved in clinical accompaniment. Lecturers will benefit by being able to update their knowledge and skills in the latest on clinical training (Mabhuda et al., 2008).

5.3.3 Clinical staff development

Staff development assists staff in gaining skills which can be used to improve clinical facilitation at each level of the programme and the staff would be able to develop guidelines based on what they would have gained from the staff development workshops. The workshops should include topics related to teaching in the clinical setting, assessment, evaluation and case study scenarios that focus on managing challenging student situations (Sanderson and Lea, 2012). At this UoT the clinical instructors mentioned that they did not have any induction on the clinical facilitation process. They indicated that they were from different backgrounds and there were new things that needed to be learnt and there were lots of expectations from the UoT management. They were also required to produce competent practitioners and everyone had to find their feet by trial and error. They further mentioned that they needed workshops on how to further develop themselves so as to be consistent in what they were doing including formulating clinical guidelines and student clinical assessments.

Orientation of new staff assists in directing them on what to do and how to strive for best staff performance. Thus if there is no orientation, it has an impact on competencies of students since staff have no direction and they work through trial and error (Hlongwa, 2009). It is, therefore, important that all new staff are properly orientated specifically on their clinical role and that there should be continuous workshops to update clinical staff. It seems that clinical instructors are organized with their work since students stated that there is a remedial plan when they were not competent in certain skills during assessments (p=0.000). This was in agreement with what most lecturers (83.3%) had indicated, i.e. that remedial plans were provided for the students that had difficulty with mastering certain skills.

5.3.4 Distant and not enough clinical facilities

In this study the clinical facilitators voiced out that some of the facilities where students are placed are far and when they reach the facilities they are already tired and it is hard to do proper student accompaniment as they are rushing to go back home before it is late. Therefore, the use of mentors was suggested. This statement was supported by McLure et al. (2013), who indicated that with shortage in the nursing faculty and lack of available close clinical sites, the use of preceptors/ mentors in facilitation of learning within the clinical environment has increased in most facilities. Clinical facilitators further voiced out that the students were also affected by the lack of and distant clinical facilities since they needed money to buy food when they are away from campus. Some parents are unemployed, and if the students are allocated close to the UoT there will be no need to worry parents with money because everything is on campus. Surprisingly, 42.9% lecturers felt that there were enough clinical facilities to place students and another 42.9% lecturers were unsure and 14.3% of them disagreed. This proved that some of the lecturers did not conduct clinical accompaniment so they were unsure of the clinical facilities utilized by the university. As far as the ages of the lecturers were concerned, 57.1% of them were older than 60 years of age. This could be the reason why they found it difficult to go for student accompaniment in clinical facilities that were far. Fourth year level students (55.2%) felt there were enough clinical placement facilities for their practice, whereas 55.6% third year students disagreed and 50% second year students agreed. However, second year students are not experienced enough to know if there are enough clinical placement areas. On the other hand, fourth year students are experienced and felt that there are enough placement areas. This means that even students are unsure of what is happening with the clinical facilities used. It is recommended that management in this university has to secure clinical placement facilities close to the university, which will save the university finances, staff energy and assist students with after-hours practice at their clinical skills laboratories.

Clinical facilitators were also concerned with accidents reported on the roads and they stated that it was scary to drive far from home. They stated that it was stressful not knowing whether one will reach the facilities or not. This also affected their performance because they constantly needed to think of travelling back to the

campus. They further stated that there was not enough learning opportunities for the students since most of the facilities are at district level. For complicated cases patients are referred to university hospitals where the students were not allocated. Therefore, students ended up not receiving enough learning opportunities. It would be great if the university signs a memorandum of understanding (MoU) with university hospitals which are close by. Therefore, it is recommended that the management finds local clinical facilities which will save the university transport and residence finances. Clinical staff will also work smart and save more time and energy.

5.3.5 Too many expectations by clinical facilities

Findings in this study show that there are problems between clinical facilitators and some of the clinical facilities. The clinical facilities felt that the facilitators have too many expectations from them and this led to conflict between them. Lack of communication between clinical placement facilities and training institutions affected student support. Therefore, according to Andrews et al. (2006) it is crucial that there is joint guidance given to students by the education and service based organizations. This will assist in good understanding and formation of a good relationship between clinical facilities and training institutions.

A great deal of groundwork has to be undertaken by the clinical facilitators prior to the placement of students to the clinical facilities by talking to staff and managers, negotiating rosters and staff to precept students and display skills as well as clinical objectives to prepare the staff for student support (Sanderson and Lea, 2012). This link between the Faculty and Health Service is a vital component of the Facilitator role because the university is located remotely from most facilities and this assists in building partnerships between the university and the health services (Sanderson and Lea, 2012). Most lecturers felt that there was an effective communication between clinical facilitators and staff in the clinical facilities regarding learning outcomes, but most of the students felt that there was lack of communication. Some of fourth year students which were 43.3%, 52% of third year students and 71% of second year students agreed that there was lack of communication. This means that there is a discrepancy between the feelings of the lecturers and those of the clinical facilitators.

A few lecturers agreed that the clinical facilities are supportive of student professional growth, skills development and practice of students. This supports the statement of the clinical facilitators that there is no support in clinical facilities and that they have many expectations. Most of the fourth year students (63.3%), which was over half the students, agreed with this statement, whereas 75% third year students and the highest percentage (81.1%) of second year students agreed with this statement (p=0.007). The two senior levels of students (third and fourth year), who had experience in the clinical sites felt that there was support in the clinical facilities by staff. Therefore, training institutions need to have meetings with each placement area to discuss and clarify roles of each team player and have a mutual understanding regarding student placements, expectations and student clinical accompaniments.

5.3.6 Challenges faced by students in the clinical area

In a study by Hlongwa, (2009), respondents who were professional nurses cited that students have problems in clinical facilities where there is little support by ward staff due to short staffing and busy schedules. They often do not have time for slow learners and these students end up doing procedures incorrectly. The placement of mentors in all clinical facilities would alleviate this problem as they will have enough time to attend to each student. The clinical instructors also raised a concern that students are not in the same level as they were from different educational backgrounds, i.e. some were from Model C schools and others were from rural schools. Those that require more time to grasp need someone who is patient with them. Some nursing staff in the facilities do not have enough time for students as they complain of staff shortage.

The clinical instructors mentioned that staff in the facilities are busy so it was their duty to make sure there was enough student support since students needed to be able to relate their problems, either social or work related, and sometimes it was not easy to do so with ward staff as they did not have time. Draper et al. (2009) cited by Ong (2013) states that support from mentors and senior nurses during student accompaniment helps prepare the students with the necessary knowledge, skills and confidence for independent practice as professional nurses.

Mongwe (2007) states that shortage of resources could have a serious impact on the health care system and that professional integrity could be jeopardized. This could also have serious impact on the quality of experiences and learning of student nurses in the clinical learning environment.

Sometimes it is of concern when clinical facilitators go to the facilities and find students doing the wrong thing and the students will tell them: “this is how it is done because there are no appropriate resources” in the clinical learning facilities. Therefore, equipment and supplies should always be made available and maintained regularly (Ayo, 2006). Andrews et al. (2006) encourage students to maximize their learning opportunities by questioning and interacting with more qualified staff to obtain the knowledge and skill they need. Most students disagreed with the statement which said that they get enough exposure in the clinical facilities. They also disagreed with the statement that there is communication between clinical facilitators and clinical facilities regarding expectations during clinical placements. These might be the reason why students are sometimes not able to acquire the appropriate clinical skills.

Therefore, it is important that students be self-directed learners where they will take charge of their learning. Clinical facilities also need to get enough resources for the sake of patient care and student learning. Despite the challenges experienced by students namely, lack of resources and staff shortage, most students across all levels of study indicated that clinical facilities were supportive of their professional growth, skills development and practice ($p=0.007$). On the other hand, 42.9% of the lecturers disagreed, indicating that clinical facilities were not supportive to students learning. Possibly students are treated well in the facilities because they indicated that they accepted constructive criticism ($p=0.074$). Lecturers (71.4%) agreed that all students knew the limitations of clinical teaching and learning process, 14.3% were neutral and another 14.3% disagreed with this. Despite the staff shortage and lack of resources and all other challenges faced by clinical staff, lecturers felt it was easy for the staff in the clinical facilities to work well with the students. Students also felt that they knew the limitations of clinical teaching and learning processes ($p=0.042$). It is

recommended that the clinical facilities should have enough functioning equipment and resources so that patients receive quality nursing care from the students.

5.3.7 Clinical programme drawn early

Clinical facilitators stated that student allocation and duty schedules were submitted late to the facilities. This creates tension between clinical facilitators and the hospital staff during clinical accompaniment. Hlongwa (2009) also found that poor organization of the R425 programme impacts on competencies of students, so it is important that the clinical programme be planned and organized early. This supports a statement by the clinical facilitators that the clinical programme should be drawn up early and sent to the clinical facilities so that there is no tension between them and the staff from these facilities.

Andrews et al. (2006) points out that if students' clinical placements are to be effective, it is important that there is good communication between training institutions and placement areas. All lecturers and most students stated that allocation dates are pre-published before student placements to the clinical facilities which means it is done well in advance at the campus but that there should be improvement in submitting them to the placement areas to prevent tension between the management in the placement areas and clinical facilitators. Students also supported the lecturers' view regarding placement dates, stating that these should be sent in advance to the placement areas before the placement of students to the clinical facilities ($p=0.017$). Regular communication between the clinical facilitators and placement areas will make it easy to discuss placement times, student needs as well as learning objectives for each level.

Most students agreed that they were informed of the specific criteria and standards for each clinical placement against which they were to be assessed ($p=0.001$). It was clear that the clinical instructors were organised and had prepared most of their work since students signed assessment contracts before being assessed ($p=0.002$) and they were informed in time before clinical assessments began ($p=0.017$). Furthermore, students availed themselves for clinical practice before they were assessed ($p=0.037$) and they felt that the assessment tools facilitated the integration

of theory and practice (p=0.000). Students and the facilitator discussed and evaluated performance against each competency, thereby identifying areas of strength and areas needing improvement (p=0.033). This statement was confirmed by students which meant there was good understanding between them and the clinical instructors. Lecturers and students responses showed that the clinical instructors were organised, however, they only needed more support from the management and lecturers.

5.3.8 Employing Mentors

Each clinical facility should have a mentor at all times for student support. This is supported by Andrews et al. (2006), who cite the importance of collaboration between the clinical facilities where there are ward managers, students, staff and mentors and in training facilities where there are clinical facilitators and lecturers.

According to Cele et al. (2002), preceptors and mentors act as role models and resource people for student nurses. They provide them with clinical teaching, orientate them in the clinical area, and allay their fears and anxiety by providing guidance, support and encouragement. Mentors also demonstrate procedures, help students with problem solving and in other facilities they do formative and summative evaluations of student nurses during clinical placements. Employment of mentors will assist both the clinical facilities and the training institution since there is minimal support of clinical accompaniment from the lecturers. Therefore, if mentors are employed they will be based at the placement facilities every day to attend to students as well as to the queries from the clinical facilities. The clinical facilitators mentioned that they will continue with their weekly accompaniment even when the management employs mentors. All lecturers (100%) agreed that clinical accompaniment does benefit students. The students were also positive about this, since 66.7% of fourth year students agreed that they benefitted from clinical accompaniment when allocated in different clinical facilities, 77.8% of third year students and 83.3% of second year students also agreed (p=0.006).

Preceptors/ mentors assist in identifying student nurses' learning needs, providing feedback and assisting in communicating with clinical facilitators regarding the progress of the nursing students in the clinical settings, as clinical facilitators might not be immediately available to accompany all student nurses (Ayo, 2006). Clinical instructors also mentioned that it would be easy to monitor student absenteeism when there is someone all the time in the facility, since in some institutions they cannot monitor student absenteeism properly. Students need to cover a minimum of 4000 hours to qualify as a professional nurse. Therefore, it is important that all training facilities employ mentors to support students and to relieve pressure from the clinical facilitators, which will also help the organization retain staff.

5.3.9. Student accompaniment tool

An accompaniment tool that could be user friendly to both clinical instructors and lecturers during accompaniment of students when they are placed in different clinical facilities needs to be developed. This tool also should be easily understood by students of all levels and be able to cover most aspects of patient care which should be mastered by all students. The accompaniment tool will also help with improving on the clinical facilitation at this UoT and other training facilities. Moleki (2008) stated that the guidelines should be made and implemented to facilitate clinical accompaniment in order to assess students' suitability in terms of value, meaningfulness and significance. The clinical facilitators suggested that the student accompaniment tool should be guided by the nursing process, and should incorporate the assessment of the cognitive, psychomotor and affective skills which will be assessed when a student is conducting any practical skill.

Buekes (2012) states that the following three main categories should be included in an accompaniment tool to be used during student accompaniment:

- Respect - which is the way students present themselves during accompaniment,
- value-sensitive communication with patients, staff as well as clinical facilitators and
- sensitivity to quality of clinical accompaniment.

This statement is supported by Labrague (2012), who added that improvement of communication and interpersonal skills is very crucial to establish a trusting patient-student relationship. This will assist students and nurses to understand patients' needs and improve the nursing care approach. The student accompaniment tool is discussed below, following the suggestions by lecturers and clinical facilitators:

(a) Nursing process

Nursing process involves assessment, planning, implementation, evaluation and record keeping (Booysen, 2009). Booysen (2009) defines nursing process as the intervention of all nursing personnel in the health illness continuum of the patient where a nursing care plan is developed to suit every patient's individual needs. Geyeer (2009) defines it as a systematic, problem solving approach to nursing that involves interaction with each patient to assess individual needs and problems, and then implement the planned nursing actions based on the assessed needs and problems. It is a scientific, step-by-step method of creating holistic, individualised care of each patient (Geyeer, 2009). Geyeer (2009) includes diagnosis as a second step of nursing process. Nursing process is divided into five steps which are: assessment, nursing diagnosis, planning, implementation, evaluation and recording.

(c) Cognitive, affective and psychomotor domains

Students must be able to combine the use of cognitive, psychomotor and affective skills to respond to patient/ client needs under their care. Patient safety must be maintained at all times while under the care of a nursing student, and clinical facilitators must monitor client needs as well as student needs (Elliott, 2002). Cognitive, affective and psychomotor domains should also be assessed at all times during clinical accompaniment to assist students with critical thinking, practice skills as well as communication skills with their patients (Bruce et al., 2011). The cognitive and affective competencies could be considered to be priorities in the preparation of the R425 diplomates (Hlongwa, 2009).

It was also cited by the clinical instructors that this tool should include a space for remedial work so that it will be easy to identify students who need more attention, a space for students to state rationale for each action and a space for scoring the outcome at the end so that the students know how weak or well they have done. Professionalism is the other important aspect to be assessed where students are checked if they are in full uniform and whether they are neat as well as their mannerism. With the above aspects the student will be assessed holistically and will be able to think critically each time they are performing any skill.

5.4 CONCLUSION

It was evident that clinical staff at this UoT were struggling as they were short staffed which makes things difficult as it was not easy to support students as expected. It was, therefore, recommended that more clinical staff be employed to prevent high failure and student dropout rates. It was also recommended that lecturers involve themselves in student accompaniment to bridge the theory-practice gap and for student support. It was further recommended that the university management employ mentors who will be based at the clinical facilities so that the management and staff in the clinical facilities have someone on the floor to communicate with and if there are problems they are solved the same time.

The findings of this study revealed that collaboration between nursing academic and nursing practice regarding clinical facilitation is vital for the development of clinical skills amongst undergraduate nursing students. However, lack of support by management, shortage of staff, lack of staff development, distant placement facilities, inadequate resources in the placement area, lack of supervision in the clinical facilities, too many expectations by clinical facilities and insufficient practice in the clinical skills laboratory due to students being placed far from the university were identified as challenges by staff and students. Lastly, guidelines for an accompaniment tool which can be developed and used during clinical accompaniment were discussed in this chapter. These guidelines may assist to develop critical thinking skills of a student and should be user-friendly for both lecturers and clinical facilitators. Theory and practice must be easily correlated.

5.5 LIMITATIONS

Limitations in this study were from the qualitative side where the focus group discussions were done with the clinical coordinator and the clinical instructors. It was a challenge to find all of them at the same time as stated in the information letter and as stated in the methodology. Each day had a challenge, it was either someone was on leave or was busy with students since clinical instructors work even during lunch time for students' practice and payback of missed skills. The focus group interview only took place when most of the students were in clinical placements.

As the study was conducted in one UoT nursing clinical department, the findings can be reliably applied only to this campus even though there are assumptions that the challenges faced by staff and nursing students in the clinical component may be the same as faced by other nursing institution across the country, but that may not be the case as each training institution has its own management and its contextual experiences, challenges and realities.

5.6 RECOMMENDATIONS

Based on the findings of the study, the following recommendations were made with special reference to nursing education and clinical training:

5.6.1 Increased collaboration between nursing academic and nursing practice

Taking into consideration the views of the clinical facilitators when they spoke about clinical facilities having too many expectations from them, one of the things that will resolve this situation is cooperation between staff in the UoT and clinical facilities in the selection of learning opportunities and formulation of clinical learning outcomes. Therefore, there should be meetings between these institutions to discuss students' needs and how they can be supported. These meetings should be organized by the clinical department in this UoT to communicate to the clinical placement areas about student support and to ensure that there is collaboration between both the facilities.

5.6.2. Employing mentors to be based at all clinical facilities for continuous student support.

For clinical facilitation to be effective in this UoT it is crucial that there is enough staff trained for the job. Therefore, the UoT management should employ mentors/ preceptors who will be placed in each placement facility as well as more clinical facilitators who will be placed at the UoT and continue with clinical accompaniment of students. The mentors will relieve the clinical instructors and staff in the placement areas will have someone to refer to whenever there are problems. This will also increase student support as students will be having someone around for their accompaniment.

5.6.3 Permission to use local clinical facilities

The limited number of accredited clinical facilities poses a challenge to the clinical instructors as they have to travel long distances for them to reach clinical placements and do their work. The university management must explore more clinical facilities close to the university that are appropriate for the achievement of the programme outcomes. A memorandum of understanding (MoU) with university hospitals which are close by must be investigated.

5.6.4 Lecturers involving themselves in student accompaniment

Clinical facilitators are short staffed in their department and they are expecting lecturers to also be part of student accompaniment. Therefore, all lecturers should be allocated to the student accompaniment role in order to bridge the theory-practice gap as well as assist the clinical instructors since there are a large number of students to be accompanied.

5.6.5 Formulation of an accompaniment tool according to the suggested guidelines

An accompaniment tool which will be user friendly to both lecturers and clinical facilitators needs to be developed. This tool also should be easily understood by students of all levels and be able to cover most aspects of patient care which should be mastered by all students. An accompaniment tool might help with improving on clinical facilitation at this UoT in future and in other training facilities that might use it when it is available. This student accompaniment tool should be guided by the nursing process, and should incorporate cognitive, psychomotor and affective skills which will be assessed when a student is conducting any practical.

5.7 FURTHER RESEARCH

- An accompaniment tool must be developed which will be easily used by both lecturers and clinical facilitators in all training programmes. This tool should also be user friendly to students and assist them to be critical thinkers.
- Another UoT which offers similar undergraduate course must be evaluated so as to ascertain whether the findings of this study are not unique to this university, particularly in the following areas: the importance of student accompaniment by lecturers, student experiences at clinical facilities and reasons why there is a problem in finding more clinical placement facilities.
- The introduction of an orientation programme and staff development programme to develop clinical facilitators at universities offering nursing courses. This will assist the clinical facilitators to have direction and be consistent in what they do in the clinical department.

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Appendix 1(a): University ethical clearance

DURBAN UNIVERSITY of TECHNOLOGY

INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC)

7 December 2012

IREC Reference Number: **REC 60/12**

Mrs N P Xaba
31 Mattison Drive
Northdale
3201

Dear Mrs Xaba

An evaluation of the facilitation of the clinical training component of an undergraduate Nursing programme at a University of Technology

I am pleased to inform you that Full Approval has been granted to your proposal REC 60/12:

The Proposal has been allocated the following Ethical Clearance number IREC 054/12. 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 deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

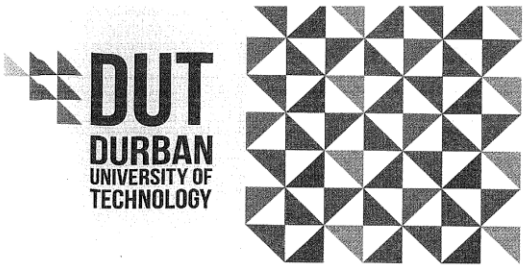
Please note that you may continue with validity testing and piloting of the questionnaire. Research on the proposed project may not proceed until IREC reviews and approves the final questionnaire.

Yours Sincerely

[redacted]

Dr D F Naude
Chairperson: IREC

Appendix 1(b) Approval of change of title



Institutional Research Ethics Committee
Faculty of Health Sciences
Room MS 49, Mansfield School Site
Gate 8, Ritson Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900
Fax: 031 373 2407
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

20 June 2014

IREC Reference Number: REC 60/12

Mrs N P Xaba
31 Mattison Drive
Northdale
3201

Dear Mrs Xaba

The assessment of the facilitation of the clinical training component of an undergraduate nursing programme at a University of Technology

I am pleased to inform you that your application for amendment to your research proposal has been approved.

Yours Sincerely

[redacted]

Prof C Napier
Chairperson: IREC

Appendix 2(a): Letter of request (Research director and post graduate support)

The Research Office
Durban University of Technology
P.O. Box 1334
Durban
4000

REQUEST TO CONDUCT A STUDY AND USE OF NURSING CLINICAL INSTRUCTORS, LECTURERS AND NURSING STUDENTS AT INDUMISO CAMPUS AS PARTICIPANTS IN MY RESEARCH

Dear Professor Moyo

I am an M Tech student at Durban University of Technology in the Faculty of Health Sciences, Nursing Programme. I am employed at Indumiso Campus in Pietermaritzburg as a clinical instructor. The tittle of my study is “An assessment of the facilitation of the clinical training component of undergraduate nursing programme at a University of Technology”.

I am requesting to recruit participants from the nursing department (lecturers, clinical instructors and all nursing students) as well as to utilize the department to conduct the study. The lecturers and clinical instructors will be approached in one of the staff meetings and the purpose of the study will be explained to them and any questions will be answered there. Those who agree to participate will be given consent forms to sign. The lecturers will be handed their questionnaires to fill in their spare time and will be requested to return them within one week. A box will be left in the front desk

for them to post the questionnaires. An appointment will be made with the clinical instructors for the focus group discussions.

The students will be asked for their study period then the purpose of the study will be explained and questionnaires will be handed by the researcher to those who will be selected using stratified random sampling. A questionnaire will take 30 minutes to complete. Confidentiality and anonymity will be ensured since their names will not appear anywhere in the questionnaires and in the report. A box will be placed on the front table for the students to post their questionnaires when they have finished.

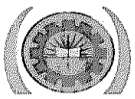
I have attached my research proposal for you to look at. Your approval and support will be highly appreciated.

Thank you
Yours sincerely

……
Nompumelelo Pearl Xaba
Student Number 21242194

Supervisor	:	Prof. J. K. Adam
Telephone Number	:	031-3735291
Co-Supervisor	:	Mrs B. T. Mkhize
Telephone Number	:	031-3735297

Appendix 2b: letter of approval from research director and post graduate support



DURBAN UNIVERSITY of TECHNOLOGY

Directorate for Research and Postgraduate Support
Durban University of Technology
Tromso Annexe, Steve Biko Campus
P.O. Box 1334, Durban 4000
Tel.: 031-3732576/7
Fax: 031-3732946
E-mail: moyos@dut.ac.za

27 February 2013

Ms Nompumelelo Pearl Xaba
c/o Department of Postgraduate Nursing Studies
Durban University of Technology

Dear Ms Xaba

PERMISSION TO CONDUCT RESEARCH AT THE DUT

Your email correspondence 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 project.

Kindest regards.
Yours sincerely

[redacted]
PROF. S. MOYO
DIRECTOR: RESEARCH AND POSTGRADUATE SUPPORT

Appendix 3(a): Letter of request (Head of Nursing Department)

The Head of Nursing Department
Durban University of Technology
P.O. Box 1334
Durban
4000

REQUEST TO CONDUCT A STUDY AND USE OF NURSING CLINICAL INSTRUCTORS, LECTURERS AND NURSING STUDENTS AT INDUMISO CAMPUS AS PARTICIPANTS IN MY RESEARCH

Dear Dr Sibiya

I am an M Tech student at Durban University of Technology in the Faculty of Health Sciences, Nursing Programme. I am employed at Indumiso Campus in Pietermaritzburg as a clinical instructor. The title of my study is “An assessment of the facilitation of the clinical training component of undergraduate nursing programme at a University of Technology”.

I am requesting to recruit participants from the nursing department (lecturers, clinical instructors and all nursing students) as well as to utilize the department to conduct the study. The lecturers and clinical instructors will be approached in one of the staff meetings and the purpose of the study will be explained to them and any questions will be answered there. Those who agree to participate will be given consent forms to sign. The lecturers will be handed their questionnaires to fill in their spare time and will be requested to return them within one week. A box will be left in the front desk for them to post the questionnaires. An appointment will be made with the clinical instructors for the focus group discussions.

The students will be asked for their study period then the purpose of the study will be explained and questionnaires will be handed by the researcher to those who will be selected using stratified random sampling. A questionnaire will take 30 minutes to complete. Confidentiality and anonymity will be ensured since their names will not appear anywhere in the questionnaires and in the report. A box will be placed on the front table for the students to post their questionnaires when they have finished.

I have attached my research proposal for you to look at. Your approval and support will be highly appreciated.

Thank you
Yours sincerely
……
Nompumelelo Pearl Xaba
Student Number 21242194

Supervisor	:	Prof. J. K. Adam
Telephone Number	:	031-3735291
Co-Supervisor	:	Mrs B. T. Mkhize
Telephone Number	:	031-3735297

Appendix 3(b): letter of permission from Head of Nursing Department

DURBAN UNIVERSITY of TECHNOLOGY

Department of Nursing
Durban University of Technology
PO Box 1334
Durban
4000

7 March 2013

Ms NP Xaba
Student Number: 21242194
Department of Nursing
Durban University of Technology

Dear Ms Xaba

PERMISSION TO CONDUCT RESEARCH IN THE DEPARTMENT OF NURSING

Your correspondence dated 15th January 2013 regarding the request for permission to conduct a research study in Nursing refers. I am pleased to inform you that you are granted permission to conduct research in the Department of Nursing (Undergraduate Nursing Programme).

The Department of Nursing wishes you the best of luck with your studies.

[redacted] .....

Head of Nursing Department

Dr MN Sibiya

THE HEAD OF DEPARTMENT - DEPARTMENT OF NURSING
DURBAN UNIVERSITY OF TECHNOLOGY
P.O. BOX 1334, DURBAN 4000
TEL: +27 (31) 373 2032/2606
FAX: +27 (31) 373 2039

Appendix 4(a): Letter of information and consent

(Lecturers and clinical instructors)

Dear Participant

Tittle of the Research Study : An assessment of the facilitation of the clinical training component of undergraduate nursing programme at a University of Technology.

Principal Investigator	:	Mrs NP Xaba (B. Cur. In Nursing administration and Education)
Telephone Number	:	033-8459046
Supervisor	:	Prof. J.K. Adams (D Tech: Clinical Technology)
Telephone Number	:	031-3735291
Co-Supervisor	:	Mrs B. T. Mkhize (M Tech: Biomedical Technology)
Telephone Number	:	031-3735291

Brief Introduction and Purpose of the Study: Thank you for willing to participate in my study. I am currently registered for the M Tech Nursing Degree at DUT.

The purpose of this study is to assess the facilitation of the clinical training component of undergraduate nursing programme at Durban University of Technology, Indumiso Campus also explore and understand your experiences with clinical facilitation. At the end of this study I will be able to determine whether the course is feasible or not and come up with recommendations based on the experiences and challenges you are facing with your help.

There will be three groups of participants in this study which will be: Lecturers who will be filling questionnaires, Clinical instructors who will participate in focus group discussions and all levels student nurses.

Outline of the Procedures: The researcher will use a questionnaire for the lecturers which will be left with you for a week to fill during your free time and you are expected to post a questionnaire in a box left in the front desk which I will pick up at the end of the week. It will take 30 minutes to fill the questionnaire.

Clinical instructors will have focus group discussions. The discussions will take an hour, but if there is further clarification required during recorded data transcription another appointment will be made with the clinical instructors. Focus group discussions will take place in the Boardroom which will be booked in time. I promise to keep your identity confidential by not using your name in a questionnaire and in the interview guide and the information given will be kept confidential. If you have any questions or you need clarification during interviews please feel free to ask.

Risks or Discomforts to the Subject: There will be no risks during this research.
Benefits: You will benefit since the study is looking at your experiences then at the end of the study I am hoping to come up with recommendations with your help.

Reason/s why the Subject May Be Withdrawn from the Study: You may withdraw at any stage of the interview with no questions asked.

Remuneration: No remuneration

Costs of the Study: You are not expected to cover any costs towards the study.

Confidentiality: All data that will be collected will be private and confidential and will be used only for the purpose of the study.

Research-related Injury: There will be no risks or injuries.

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

Head of Department	:	Dr N. Sibiya
Telephone Number	:	031-37732032
Supervisor	:	Prof. J. K. Adam
Telephone Number	:	031-3735291
Co-Supervisor	:	Mrs B.T.Mkhize
Telephone Number	:	031-3735297
Ethics administrator	:	031 373 2900.

Appendix 4(b): Letter of information and consent (Students)

Dear Participant

Tittle of the Research Study: An assessment of the facilitation of the clinical training component of undergraduate nursing programme at a University of Technology.

Principal Investigator	:	Mrs NP Xaba (B. Cur. In Nursing administration and Education)
Telephone Number	:	033-8459046
Supervisor	:	Prof. J.K. Adam (D Tech: Clinical Technology)
Telephone Number	:	031-3735291
Co-Supervisor	:	Mrs B. T. Mkhize (M Tech: Clinical Technology)
Telephone Number	:	031-3735291

Brief Introduction and Purpose of the Study: Thank you for willing to participate in my study. I am currently registered for the M Tech Nursing Degree at DUT.

The purpose of this study is to assess the facilitation of the clinical training component of undergraduate nursing programme at Durban University of Technology, Indumiso Campus also explore and understand your perceptions regarding clinical facilitation. At the end of this study I will be able to determine whether the course is feasible or not and come up with recommendations based on your perceptions.

There will be three groups of participants in this study which will be: Lecturers who will be filling questionnaires, Clinical instructors who will participate in focus group discussions and all levels student nurses.

Outline of the Procedures: The researcher will use a questionnaire with structured questions to conduct the interview. You will be given 30 minutes to fill in the questionnaire when you finish filling it in you will then post it in a box which will be provided on the front table in class. I promise to keep your identity confidential by not using your name in a questionnaire and the information given will be kept confidential. If you have any questions or you need clarification during interviews please feel free to ask.

Risks or Discomforts to the Subject: There will be no risks during this research.

Benefits: You will benefit since the study is looking at your perceptions regarding clinical facilitation then at the end of the study I am hoping to come up with the solutions with your help.

Reason/s why the Subject May Be Withdrawn from the Study: You may withdraw at any stage of the interview with no questions asked.

Remuneration: No remuneration

Costs of the Study: You are not expected to cover any costs towards the study.

Confidentiality: All data that will be collected will be private and confidential and will be used only for the purpose of the study.

Research-related Injury: There will be no risks or injuries.

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

Head of Department	:	Dr N. Sibiya
Telephone Number	:	031-37732032
Supervisor	:	Prof. J. K. Adam
Telephone Number	:	031-3735291
Co-Supervisor	:	Mrs B. T. Mkhize
Telephone Number	:	031-3735297
Ethics administrator	:	031 373 2900.

Appendix 5: Consent form

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, _____ (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	**Date**	**Time**	**Signature / Right Thumbprint**

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	**Date**	**Signature**
_____	_____	_____

Full Name of Witness (If applicable)	Date	Signature
_____	_____	_____

Full Name of Legal Guardian (If applicable)	Date	Signature

Appendix 6a: Questionnaire (lecturer)

Title: An assessment of the facilitation of the clinical training component of undergraduate nursing programme at a University of Technology.

SECTION A

Lecturer's Demographic Information		✓ **Tick in an appropriate space**
1.	**Gender**	
1.1	Female	
1.2	Male	
2.	**Age**	
2.1	30 -40 years	
2.2	40 -50 years	
2.3	50 -60 years	
2.4	60 -70 years	
3.	**Years of service as a lecturer at Indumiso Campus (if applicable)**	
3.1	6months – 1 year	
3.2	1– 2 years	
3.3	2 – 3 years	

SECTION B

Each item has 5 possible responses, they range from 1=strongly agree to 5=agree nor disagree. please tick the response that clearly represents your degree of agreement or disagreement with the statement. Please respond to all statements.

***KEY*: 1 = STRONGLY AGREE 2=AGREE 3= DISAGREE**

4= STRONGLY DISAGREE *5 = NEITHER AGREE NOR DISAGREE*

STATEMENT	1	2	3	4	5
Clinical Placement area					
1. Placement dates are pre-published before the placement of students to the clinical facilities.					
2. Students get enough clinical exposure in the clinical placements					
3. There is enough clinical accompaniment by clinical instructors in the placement area.					
4. There is an effective communication between clinical facilitators and staff in the clinical facilities re- learning outcomes.					
5. Students and clinical facilitators have effective communication re-expectations during clinical placements.					
6. There is effective communication between clinical facilitators and clinical staff re- expectations during clinical placement.					
7. Students and clinical facilitators have effective communication re-expectations during clinical placement.					
8. As a lecturer I also visit the clinical area for accompaniment of students.					
9. The learning needs of students are clarified to the students.					
10. There is a joint responsibility between the lecturers and the clinical staff to develop the student nurses.					
11. The development and teaching of the student nurses is only the responsibility of the university.					
12. The clinical facilities are supportive of professional growth, skills development and practice of students.					
13. There is a good relationship between clinical facilitators and the clinical staff in clinical placements.					
14. There are enough clinical placement facilities to place students for clinical practice.					

SECTION C: Clinical teaching and learning					
15. The university has enough space for clinical teaching and learning activities.					
16. The university has enough equipment and material resources for demonstration and feedback of clinical skills.					
17. The clinical placement areas have enough equipment and material resources for demonstration and feedback of clinical skills.					
18. Students are theoretically prepared before they are sent to clinical facilities.					
19. Nursing students are willing to learn.					
20. Students accept constructive criticism.					
21. All students know the limitations of clinical teaching and learning process.					
22. Remedial plan is implemented if there is a student fails to master the skill.					
23. Clinical facilitators get full support from the lecturers.					
24. Clinical accompaniment does benefit students.					
25. In a separate page please make recommendations for the development of a tool that could be easily used by both clinical instructors and lecturers during clinical accompaniment of students when they are placed in different clinical facilities.					

SECTION D: Clinical assessment					
26. Students are informed of the specific criteria and standards for each clinical placement against which they will be assessed.					
27. All students sign an assessment contract before being assessed.					
28. Students are informed in time before clinical assessments starts.					
29. Students avail themselves for clinical practice before they are assessed.					
30. The assessment tools facilitate the integration of theory and practice.					
31. There is confidentiality of the assessment outcome for each student.					
32. Student and the facilitator discuss and evaluate performance against each competency thereby identifying areas of strength and areas needing improvement.					
33. Lecturers have an input in the development of assessment tools.					
34. As lecturers we are involved in clinical assessments of students.					

Appendix 6b: Questionnaire (Student)

Title: An assessment of the facilitation of the clinical training component of undergraduate nursing programme at a University of Technology.

SECTION A

Student's Nurses Demographic Information		✓ ***Tick in an appropriate space***
1.	**Gender**	
1.1	I am a female	
1.2	I am a male	
2.	**Age**	
2.1	18 – 20 years	
2.2	20 -25 years	
2.3	26 – 30 years	
2.4	31 – 35 years	
2.5	Above 35 years	
3.	**Level of training**	
3.1	I am in my fourth year of study	
3.2	I am in my third year of study	
3.3	I am in my second year of study	

SECTION B

Each item has 5 possible responses, they range from 1=strongly agree to 5=*agree nor disagree*. please tick the response that clearly represents your degree of agreement or disagreement with the statement. Please respond to all statements.

***KEY*: 1 = STRONGLY AGREE 2=AGREE 3= DISAGREE**

4= STRONGLY DISAGREE *5 = NEITHER AGREE NOR DISAGREE*

STATEMENT	1	2	3	4	5
Clinical Placement area					
1. Placement dates are pre-published before the placement of students to the clinical facilities					
2. We receive a manual containing all rules regarding clinical practice, procedures, forms and strategies prior to commencement of clinical placements					
3. I get enough clinical exposure in the clinical placements					
4. There is enough clinical accompaniment by clinical instructors when we are in the placement area					
5. Students and clinical facilitators have effective communication re-learning outcomes					
6. There is an effective communication between clinical facilitators and staff in the clinical facilities re- learning outcomes					
7. We as students and clinical facilitators have effective communication re- expectations during clinical placements					
8. There is effective communication between clinical facilitators and clinical staff re- expectations during clinical placement					
9. We as students and clinical facilitators have effective communication re- expectations during clinical placement					
10. Student's learning outcomes are distributed to the placement area before placement of students					
11. The learning needs of students are clarified to us as students					
12. The clinical facilities are supportive of professional growth, skills development and practice of students.					
13. There are enough clinical placement facilities to place students for clinical practice					

SECTION C: Clinical teaching and learning					
14. The university has enough space for clinical teaching and learning activities					
15. The university has enough equipment and material resources for demonstration and feedback of clinical skills					
16. The clinical placement areas have enough equipment and material resources for demonstration and feedback of clinical skills					
17. The term “self-directed learning” is clear to us as nursing students					
18. As a student I understand my responsibilities regarding clinical facilitation					
19. We are theoretically prepared before we go for clinical facilitation.					
20. As a nursing student I am willing to learn.					
21. Students accept constructive criticism.					
22. All students know the limitations of clinical teaching and learning process.					
23. Remedial plan is implemented if the we as students are not yet competent in a certain skill.					
24. As a student I benefit from clinical accompaniment when allocated in different clinical facilities.					
25. Student clinical accompaniment should only be done by clinical facilitators.					
26. Lecturers should not be involved in clinical accompaniment of students.					
27. Lecturers are involved in student clinical facilitation and accompaniment.					

SECTION D: Clinical assessment					
28. As a student I am informed of the specific criteria and standards for each clinical placement against which I will be assessed					
29. All students sign an assessment contract before being assessed					
30. We are informed in time before clinical assessments starts					
31. I avail myself for clinical practice before I am assessed					
32. We are informed in time of the skills we will be assessed on					
33. The assessment tools facilitate the integration of theory and practice					
34. There is confidentiality of the assessment outcome for each student					
35. Student and the facilitator discuss and evaluate performance against each competency thereby identifying areas of strength and areas needing improvement					

Appendix 7: Interview guide (Clinical facilitators)

1. **Roles**

2.1 What does clinical facilitation mean to you?

2.2 What are your roles as a clinical instructor?

2. **Experiences**

2.1 What are the experiences that you feel can distract you from doing your job as a clinical instructor properly?

2.2 Do you think it is possible to change that? If yes what would be your suggestions?

2.3 Do you think the students are coping with the clinical expectations?

2.4 Do you receive enough support as a clinical instructor by management and other colleagues? If not how would you like them to support you?

2.5 What do you think about clinical facilitation and learning by facilitator and student ratio?

3. **Benefits**

3.1 Do you think clinical accompaniment benefits the students? If yes/no please explain how

3.2 Are there any restrictions during accompaniment of students? If there are please explain.

3.3 What changes do you think can be made to improve these?

3.4 As a clinical instructor how do you think this university can produce competent, productive, highly skilled and enthusiastic and competent health practitioners?

3.5 Is there any other thing regarding clinical instruction that you would like to add that will benefit you and the others?

3.6 What recommendations can you make for the development of a tool that could be easily used by both clinical instructors and lecturers during

clinical accompaniment of students when they are placed in different clinical facilities