

GUIDELINES TO ENHANCE THE HUMAN CARING ATTRIBUTES AMONGST THE UNDERGRADUATE NURSING STUDENTS AND NURSE GRADUATES IN KWAZULU-NATAL

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Declaration

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is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources).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

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Abstract

Background

The nursing profession needs caring individuals. Graduating nurses who interrelate with others in an empathetic and compassionate manner is obligatory for nursing to uphold the image of being a caring profession. Not only nursing's reputation is at stake, but also having caring or uncaring nurses does have financial bearing in healthcare. South Africa is witnessing a sharp increase in medical malpractice litigation as patients increasingly become aware of their rights in a setting of an overburdened health system with limited resources. The consequences of increased litigation are a further reduction in the state's ability to finance health care because of large pay-outs and a continuing increase in malpractice premiums in the private sector.

Aim

The aim of this study was to critically analyse the role played by theoretical and clinical learning experiences, in influencing the development of human caring attributes among undergraduate nursing students and newly graduated professional nurses (less than five years of experience) in the province of KwaZulu-Natal (KZN) in order to establish clear guidelines that could be used by lecturers to enhance human caring attributes among the nursing students.

Methodology

The convergent mixed method design (Qualitative + Quantitative) was used in the current study. This method allowed the researcher to use concurrent timing to implement the qualitative and quantitative strands during the same research process, prioritise both methods equally, but kept the strands independent and only mixed the quantitative and qualitative results during the overall interpretation. The quantitative aspect enabled the researcher to gather information from undergraduate nursing students and newly graduated professional nurses (less than five years of experience) from both selected KZN

College of Nursing (KZNCN) and University of Technology (UoT) using the Caring Behaviour Inventory Tool after the researcher received permission from the author. The qualitative aspect allowed the researcher to gather information from the newly graduated professional nurses (less than five years of experience) and nursing students' from KZNCN and UoT, understanding of the concept human caring, to explore the intrinsic and extrinsic factors related to the development of human caring attributes from their perspectives and to determine their experiences in both the theory and the clinical setting that contributed to the development of human caring attributes through semi-structured in-depth interviews. Focus group discussions with nurse educators from the selected KZNCN and UoT as well as nurse managers and nursing students from DUT and KZNCN practice, also enabled the researcher to gather some rich information from these participants. The quantitative data was analysed using version 25.0 of the Statistical Package of Social Sciences and the qualitative data was analysed using Tech's method of data analysis.

Findings

The quantitative data showed that the nursing students and newly graduated professional nurses had a clear idea regarding the constituents of caring in nursing. The findings identified a caring nurse as being giving the patient information, so that he/ she can make a decision, supporting the patient, giving good physical care, giving instructions or teaching the patients, treating patient information confidentially, making the patient physically or emotional comfortable, helping to reduce the patients' pain, encouraging the patient to call if there are problems, showing respect for the patient and giving good physical care. The qualitative findings of the current study revealed that there was a unanimous agreement amongst the nurses irrespective of their professional ranks about the understanding of the concept human caring. These findings also revealed that the lack of human and material resources, unconducive working environment and lack of management support impact negatively on the quality of patient care as

well as nursing students' integration of theory into practice. The researcher also established clear guidelines that can be used by lecturers to enhance human caring attributes among the nursing students. Recommendations for implementation and evaluation of the effectiveness of the developed guidelines were suggested for future research.

Key words: Student nurse, human caring, theoretical learning, clinical learning environment, feedback and mentoring.

Dedication

This study is dedicated to my late brother, Mr Siyabonga F. Mazibuko, as well as to my parents, Mrs Ntombi W. Mazibuko and Mr Kenny O. Mazibuko, for instilling in me a life-long learning mentality, self-confidence and resilience.

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Glossary of terms

Carative

Carative is the philosophy and the theory of human caring. Dr Jean Watson uses the term 'carative' instead of 'curative' to distinguish between nursing and medicine. "Whereas curative factors aim at curing the patient of the diseases, carative factors aim at the caring process that helps the person attain (or obtain) health or peaceful death" (Watson 1979).

Caring

Caring is the nurse's moral ideal of preserving human dignity by helping a human being to find significance in infirmity and affliction in order to bring back, encourage, improve, and safeguard human dignity (Watson 2002; 2008).

Clinical learning environment (CLE)

Chan (2004: 666) maintains that the clinical learning environment is a reciprocal arrangement of services within a clinical setting that influence the students' clinical learning outcomes. The CLE allows nursing students to develop attitudes, competences, interpersonal communication skills, critical thinking and clinical problem solving abilities (Chan 2004: 666). Papp, Markkanen and von Bonsdorff (2003: 263) point out that the CLE includes all that surround the learner nurse, including the clinical surroundings, equipment, personnel, patients, nurse mentor, nurse educator. In this study, the CLE encompasses all the units in the public or private institutions where DUT undergraduate nursing students are allocated to work as part of the clinical component of the programme. Furthermore, in each unit nursing students have an opportunity to nurse patients with different diagnoses and diseases as well as different equipment. The professional nurses and the nurse educators are part of the CLE, are there to support, and facilitate learning within the CLE.

Nurse Managers

Nursing Managers are qualified professional nurses who are employed in managerial positions at a health care establishment. They may be nursing managers who are responsible for the management of nursing staff. Deputy nursing managers are second in charge of nursing staff. Unit managers are the operational managers of nursing units.

Clinical preceptor

Clinical preceptor is a qualified professional nurse employed by a nursing education institution to work closely with a group of nursing students in a particular clinical facility or facilities to maximize the clinical learning experience of student nurses in formal nursing education programmes (The Nursing Education Stakeholders [NES] Group 2012).

Quality patient care

Quality patient care is defined as achieving the excellent outcomes using the available resources (Department of Health 2009: 5). Quality patient care refers to the safety, effectiveness and proficiency with which nurses provide patient care (Department of Health 2009:5). Quality of care defined as the defined set of principles implemented by professionals in order to accomplish the utmost benefit to the patient (Murray, Zentner and Yakimo 2009:42).

Nursing education institution (NEI)

The Nursing Act, 33 of 2005 defines a 'nursing education institution' as any nursing education institution accredited by the South African Nursing Council (SANC) for the education and training of nursing students/learners (South Africa (Republic) 2005: 6).

List of acronyms

Acronym	Full word/sentence
ANM	Area nurse manager
CI	Clinical Instructor
CBI-42	Caring Behaviour Inventory Tool
CF	Clinical facilitators
CPC	Clinical Placement co-ordinator
CPC	Clinical Programme co-ordinator
CSN	Community Service Nurse
CTD	Clinical Teaching Department
CTU	Clinical Teaching Unit
DOH	Department of Health
HIV	Human Immunodeficiency Virus
KMO	Kaiser-Meyer-Olkin
KZN	KwaZulu-Natal
KZNCN	KwaZulu-Natal College of Nursing
KZNHF	KwaZulu-Natal Health Facilities
LN	Learner nurse
MDR	Multiple Drug Resistant
MTT	Ministerial Task Team
NCS	National Core Standards
NE	Nurse educator
NHI	National Health Insurance
NPR	Nurse Patient Relationship
PHC	Primary Health Care
PN	Professional Nurse
PPE	Positive Practice Environment
PRNCPL	Campus Principal

Acronym	Full word/sentence
SNE	Senior Nurse Educator
SPSS	Statistical Package of Social Sciences
TB	Tuberculosis
UK	United Kingdom
UoT	University of Technology
USA	United States of America
WHO	World Health Organization
XDR	Extreme Drug Resistant

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION

The nursing profession is arguably one of the most important human professions. It is one of the few professions where empathy and a nurturing disposition is a major criteria and an indispensable job description. That is why all over the world, nurses are considered 'angels' sent to provide care to the sick, weak and vulnerable. Caregivers are expected to be tender-hearted, enthusiastic, trustworthy and competent. These characteristics are attained by adopting all the relevant professional philosophies and are performed for the benefit of the healthcare user, the individual caregiver, the nursing fraternity at large, the general public and the realm in which the caregivers performs (Jooste 2018: 25-26).

At the core of the nursing profession is the predisposition to caring. Labrague (2012) and Watson (2002) aver that training and/or education in nursing would be incomplete without the incorporation of empathy, care and psychosocial nurturing. Authors have tried to characterise what institutes caring; however, although carefully planned to be a worldwide occurrence, this judgement is still abstruse and hard-hitting to describe (McEnroe-Petitte 2014: 80-83). Caring, according to Watson (2002; 2008) is the caregiver's ethical norm of conserving human sense of self by helping a human being to discover implication in infirmity and affliction to re-establish, give self-assurance, get better, and retain self-worth.

One way through which a would-be nurse's propensity for the indispensable qualities of caring and nurturing, is through the pre-registration nursing instruction. As rudimentary excellence of the nursing career, it is assumed that human caring can be refined, transmitted, and evaluated through nursing education and, when presented early, demonstrated and colloquial armour-plated throughout the core curriculum (Alpers, Jarrell and Wotring 2013: 66-69). Through anticipative Nursing Education Institution (NEI) demonstrating and role exhibiting, learner nurses can be proficiently skilled to develop the capability of caring (McEnroe-Petitte 2014: 80-83).

Caring in the learner educator relationship has been identified as indispensable to nursing training for two important motives. Firstly, it is imperative to ensure that would-be nurses experience empathy and compassion during the learning period. That is the only way they can translate that ethos into real life situation when they become fully-fledge nurses. It would be imprudent to train nurses in ways that are not compassionate, and expect them to be compassionate on the job. (Watson 1988, Diekelmann 1990; Brown 1991; Green-Hernandez 1991; Keen 1991; Miller 1991; Sheston 1991; Hughes 1992). Secondly, the emancipation of learners to the reason for themselves necessitates a trusting and caring setting (Watson 1990; Hedm and Donovan 1991). Previous studies have examined whether caring as an outlook can and should be taught to learner nurses (Romiszowski 1981; Jarvis 1984; Dawson 1992). Dawson (1992) argues that the principled code of coaching caring as an arranged approach to learner nurses must be interrogated, particularly if caring by learner nurses is to be evaluated. Condon (1992: 14-19) states that caring must be professed as such by the healthcare provider and the client. The investigator has not found a research study that has been conducted at a university of technology that considered whether the perception of caring by students is significant in the learning of caring.

1.2 BACKGROUND AND RATIONALE

Jooste (2018: 25-26), argues that the nursing profession originated because of the need to be kind-hearted towards others, and the need to provide care and support to the sick and/or vulnerable. To be a caring person, one has to understand that the provisions of others often take supremacy over the requirements of the self. Nevertheless, a compassionate caregiver also takes into cognisance the need to first be taken care of, or be in a good condition to be able to provide good care. The art of this lies in the subtle balancing of fulfilling one's caring requirements and gratifying the caring needs of consumers. A caring nurse behaves as a considerate, loyal, meticulous, positive and proficient person. These behavioural/character traits are acquired by internalising all the relevant nursing morals and are acted out to the benefit of the consumer, the individual nurse, the profession at large, the general public and the realm in which the nurse practices (Jooste 2018: 25-26).

The study aimed to analyse the role played by theoretical and practical learning experiences in influencing the development of human caring attributes among undergraduate DUT nursing students. The overarching goal is to establish clear practice guidelines that may be used by lecturers to enhance human caring

attributes among the undergraduate nursing students. Watson (2005: 51 52) describes nursing involvements associated with human care as the experimental Caritas progressions. The above-mentioned framework is limited in that it is restricted to caring attributes as an end in itself to be achieved. It also does not comprise the association amongst kind and practical/ client results of excellence of care.

1.3 PROBLEM STATEMENT

As earlier stated, the nursing profession requires caring persons. It is important to ensure that students admitted into the nursing degree are made aware of the onerous role they play in society. When individuals without requisite emotional intelligence and empathy become nurses, they constitute both an image and economic risk to the profession (Nadelson, Zigmoid, Nadelson, Scaden and Collins 2016: 7). Pepper and Slabbert (2011: 29) affirm that South Africa is observing a high-pitched escalation in medicinal error litigations as clients are becoming increasingly conscious of their constitutional rights. The magnitude of increased legal actions are: (i) a supplementary decrease in the government's capability to supply healthcare institutions because of huge amounts of money paid to claimants; and (ii) a lasting escalation in medical error payments in the private subdivision. According to Dhlomo (2017), KwaZulu-Natal (KZN) Department of Health is anticipated to reimburse to the tune of R241 million for litigations in 2018. In 2017, it was stated that the department received litigation dues amounting to R10 -13824. Breier *et al.* (2009: 112) argues that nurse educators across the board spoke of a drop in the standards of nursing, with the major reason being a lack of care among nurses and learner nurses. The researcher believes that the human caring attributes from nurses need to be enhanced during the training period in both theoretical and clinical settings. The Department of Health (2013: 42) affirms that there is a necessity to revive the honourable and considerate character of the nursing profession, taking into consideration the socio-political atmosphere, which influences the provision of care (DOH 2013: 42).

Recent studies indicate that the clients are increasingly reporting diminished altitudes of caring by healthcare providers (Porr and Egan 2013: 35-43). Subsequently, nursing lecturers and health institutions are backing up efforts that endorse considerate actions of caregivers and are functioning to assure enduring and conspicuous ethical principles of compassion for existing and forthcoming nurses. With the public outcry to uplift the standards of caring amongst present and future nurses, nurse educators are being requested to invent innovative and

effective instructional approaches that coach healthcare providers about compassion. Additional research is desirable concerning the methods wherein such groups might be raised within facilities and institutes. Not much is known about what is it that the NEIs required to generate, uphold and augment caring in nursing education. For instance, how does continuity of task within a facility disturb educators' capability to care for learner nurses? There exists no clear picture of the outcomes of caring in nursing education other than the unapproved supposition that compassion by the educator will yield compassionate learner nurses. Consequences for instance instructor and learner self-actualisation are contingent but have not been explored (Porr and Egan 2013: 35-43). The power of caring is discussed by Morse and other scholars (1991) in their investigation of caring as a concept in nursing. These authors suggest that the power that resides in nurses' caring has not been fully recognised. It is clear that facilitators must endeavour to classify and recognise the power of caring in nurse training.

1.4 AIM OF THE STUDY

This study aimed to develop guidelines to enhance human caring attributes among the undergraduate nursing students and nurse graduates (less than five years of experience) in KZN.

1.5 OBJECTIVES OF THE STUDY

The objectives of the study are to:

- Assess the nursing students' and nursing educators' understanding of the concept of human caring.
- Explore and describe the intrinsic and extrinsic factors related to the development of human caring attributes from the perspective of the nursing students, newly graduated professional nurses, and nurse educators.
- Determine the nursing students' and newly graduated professional nurses (less than five years of experience) experiences in both the theory and the clinical setting that contributed to the development of human caring attributes according to their perspective.
- Explore and describe the skills and abilities that are needed to be successful at caring from the perspectives of the participants.
- Determine the association between the working environment and the development of human caring attributes.
- Establish clear guidelines for lecturers and the clinical facilitators to be used to enhance human caring attributes among the nursing students.

1.6 SIGNIFICANCE OF THE STUDY

Findings from the study may be used to advance the instruction and preparation of learner nurses by the clinical instructors and theory nurse facilitators NEI in refining and re-enforcing their teaching methods and strategies in both theory and clinical education. thereby enhancing the human caring attributes amongst undergraduate nursing students.

The conclusion of this investigation will serve as a template for policymakers to adapt and improve their policies about instruction and preparation of learner nurses at the NEI and address the trials scholars come across in the clinical learning environment (CLE). The findings could also form the baseline information for further research to add to the body of knowledge and education of nurses on ways to enhance human caring attributes amongst pre-graduate learner nurses.

This research study also adds value to the nursing care enormously, through dealing with trials in the working environment that hinders the efficiency of teaching and training of learner nurses which in turn can augment the expansion of human caring attributes amongst undergraduate learner nurses which are forthcoming professionals and ultimately assist to recover the excellence of client care and decrease the extraordinary level of litigations against the Department of Health.

1.7 STRUCTURE OF THE THESIS

Chapter 1: Orientation to the study

It affords an outline of the research strategy, which comprises the institution, and contextualises the research study, the purpose and objectives, the hypothetical underpinning and model, together with an interpretation of the conceptions. A transitory summary of the investigation strategy and approach was also provided.

Chapter 2: Literature review

This chapter discusses the related literature and describe the four key concepts of the study namely adult scholarship, conceptions caring, clinical learning environment and instructive performance. The chapter includes the identification of the knowledge gap in the literature relating to the key concepts of the study.

Chapter 3: Theoretical framework

This chapter explains the theoretical underpinning of the study, the ten carative factors relating to the caring philosophy by Jean Watson, adult learning theories, and the four main concepts: nursing, environment, Person and health.

Chapter 4: Research design and methods

The methodological presentation of the study is outlined in this chapter. The methodology included both qualitative and quantitative phases of the study.

Chapter 5: Presentation of quantitative findings

This chapter provides the presentation of quantitative data findings. The quantitative results are presented with a combination of graphics and themes.

Chapter 6: Presentation of qualitative findings

This chapter provides a presentation of qualitative data findings. The quantitative results are presented with a combination of graphics and themes.

Chapter 7: Discussions of findings

The interpretation of the study results for both the quantitative and qualitative phases of the study are covered in this chapter.

Chapter 8: Guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal

This chapter provides the development of guidelines from the research study results.

Chapter 9: Conclusion, limitations and recommendations of the study

This chapter concludes the study by providing a brief overview that includes the conclusions, limitations and recommendations of the study.

1.8 SUMMARY OF THE CHAPTER

The perception of caring is often used in the nursing literature as an essential characteristic, but it is intangible, ambiguous and not well-defined. Hence, the study aimed to critically analyse the role played by academic and experimental learning practices in promoting the growth of human caring traits amongst pre-graduate learner nurses and newly qualified trained healthcare providers (less than five years of experience) in KZN to establish clear guidelines that could be used by lecturers to enhance human caring attributes among the nursing students. Chapter One presented the research study by defining the contextual

foundation of the study, the inquiry problem, the hypothetical underpinning and prototype, together with an interpretation of the conceptions. Chapter Two is devoted to the detailed appraisal of accessible writings on four occurrences, namely grown-up knowledge, conceptions compassion, experimental knowledge milieu and instructive performs.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, literature was reviewed on four phenomena, namely adult learning, concepts caring, clinical learning environment and educational practices. Chapter 2 therefore serves four purposes. In the first place, it is a presentation and discussion of adult learning and andragogy. Secondly, it is an in-depth description of the concept caring. In the third place, it is an exploration of the clinical learning environment. In the fourth place, it is an investigation of educational practices that may influence the development of caring attributes and an exploration of nursing curriculum and various teaching and learning strategies.

The literature review is a process whereby an investigator assesses the existing knowledge about the topic under research to further accentuate or disagree with positions, as well as identify gaps for further study (Polit and Beck 2017: 87-88). The literature review also offers a structure for founding the significance of the scholarship including a yardstick for associating the investigation discoveries with other suppositions. Research investigations must enhance the existing writings related to the subject matter, and writings subdivisions in research plans are usually designed from the principal problematic issue to the lesser tricky issue that directs straight into the approaches of the research investigation (Creswell and Creswell 2018: 26-27).

2.2 ADULT LEARNING THEORY (ANDRAGOGY)

According to the Children's Act no. 38 of 2005 (South Africa 2005: 24), as amended the legal age for a person to be considered an adult in South Africa is eighteen years. In definition, an adult is a person who has attained the age of maturity as specified by law (Dictionary.com 2013). Thus, nursing students and nurse graduates are adult learners involved in nursing programmes that require both a theoretical and clinical exposure and their skills far exceed the memorisation of facts and mere regurgitation of knowledge. For them to be lifelong learners they should be equipped with skills to self-reflect, self-critique, self-direction and being able to synthesize knowledge, apply knowledge and reason critically (Botma *et al.* 2014: 21). This implies that nurse educators must utilise learner-centered teaching and learning approaches based on the principles of adult learning to enhance the development of human caring attributes.

Pedagogics was the suppositions associated with accomplishing information including learner capabilities on which instructors may perhaps form the basis for their coaching approaches, amongst the 7th and 12th centuries. Pedagogy originated from the modest European institutes and emanated to manage materialistic institutes and academies as they began to look as if the finish of the 12th century (Knowles 1970: 40). The concept 'pedagogy' was created from dualistic Greek terms: remunerated denoting 'child' and 'agogus' implying 'front-runner of'- consequently, accurately denoting an important person in charge of a young individual that transforms and is keen on the "art and science of coaching offspring" (Ozuah 2005: 83). The primary supposition prepared associated with the reliance on scholars' merits; by insinuation, learners may perhaps not distinguish their knowledge acquisition desires. The subsequent hypothesis remained that knowledge acquisition required to be learner-oriented. The other supposition emphasised external inspiration as an important fascinating strength for information attainment. Henceforth, learners should be enthused through prizes and reprimand; the current supposition was at that moment rooted in the admiration contrasted with punishment precept.

The concluding hypothesis of pedagogics was that any former scholar encounter stood inappropriate, educationalists do not necessitate to consider the scholar's previous encounters (Ozuah 2005: 83). Employing the distribution of primary institutes all over European and North American countries far along in the course of the 18th to 19th eras, pedagogics remained accepted, reformed and toughened for the reason that the aforementioned remained the single instructive approach by the period (Knowles 1970: 40; Ozuah 2005: 83). Ozuah (2005: 83) argues that pedagogy was an educator centred model.

The term andragogy was originally formulated by the German teacher, Alexander Kapp, in 1833 (Nikolova, Zafirova-Malcheva, Stefanova and Boytchev 2013: 156). In 1926, Eduard Lindeman wrote extensively about andragogy (Ozuah 2005: 83). Andragogy meaning 'man' is the opposite of pedagogy, denoting 'child' and agogus meaning 'leading' (Knowles 1973: 43). Extensive work by Knowles and other facilitators resulted in the advancement of new assumptions about mature learners (Ozuah 2005: 83). Knowles wrote that andragogy is another model of hypothesis scholars used in conjunction with the pedagogical model of assumptions useful within a given circumstance (Knowles 1970: 43). Nevertheless, experts of adult learning theory used to progressively transfer learners commencing the dependence of pedagogics in the course of incremental liberation and self-reliance (Ozuah 2005: 84).

2.2.1 Adult learning theories

According to Ozuah (2005: 85), numerous learning models described in the literature may assist to realise features of grownup wisdom. The five main philosophies are the interactive principle, intellectual principle, constructivist model, evolving principle, and the humanistic principle (Ozuah 2005: 85).

2.2.1.1 Behavioural Theory

The Behavioural Model proposes that facilitator writes the learning objectives, forward motion, asks for nurse learners' answers, and delivers a strong point to well-established scholars. The nurse instructor for that reason takes full responsibility for knowledge acquisition progression (Ozuah 2005: 85). The educational aim remains an alteration of obvious actions (Ozuah 2005: 85). Stimuli in the surroundings can result in behavioural changes (Palis and Quiros 2014: 115).

2.2.1.2 Cognitive Theory

Intellectual philosophy and scholarship places emphasis on cognitive and expressive practices and the opinion and indulgence of knowledge, and activities (Palis and Quiros 2014: 115). Intellectual model's objective remains the accomplishment of practical information and investigative proficiency (Ozuah 2005: 85). Intellectual philosophies deliberate knowledge acquisition by intellectual as collective enactment happening in humanity and discriminatory by the state of affairs prevailing currently (Palis and Quiros 2014: 115). The instructor tries to relate new vocabulary with the ones from the past and is concerned with the scholar contemplation progression (Ozuah 2005: 85).

2.2.1.3 Constructivist Learning Theory

Learning is the acquisition of a shared comprehension and the advancement of the process of information acquirement. The educationalists together with the learner develop the learning outcomes and centre the knowledge acquisition in convenient encounters (Ozuah 2005: 85). According to constructivists' viewpoint, scholars produce information and implication greatest while they recall previous encounters which assist them to recognise ways in which innovative knowledge relates to the present indulgent thought/ suggestion; this model has sentimental value to all vigorous learner-centred knowledge acquisition (Slavich and Zimbardo 2012: 572). Constructivists concur that the scholar, the scholar, rather than the teacher is fundamental to creating information and acquiring facts is an active process (Botma, Brysiewicz, Chipps, Mthembu and Phillips 2014: 16-17).

2.2.1.4 Developmental Theory

Determination of knowledge acquiring remains the accomplishment to each learner's utmost prospective. The scholarship outcomes are founded on standards, suitable actions, and competencies or information for precise altitudes or phases of progression. The instructor regulates the learners' phase and reacts properly (Ozuah 2005: 85).

2.2.1.5 Humanistic Theories

These philosophies emphasise a person's perspective for self-discovery, self-direction and inner drive (Palis and Quiros 2014: 115). Based on the supposition that innately persons have an ordinary predisposition to gain knowledge of, the plan of humanistic theories is to gratify the learners' needs for professional and personal development (Ozuah 2005: 85). Humanistic theories embrace the description of a grown person's driving force and character to knowledge acquisition utilising self-directed learning - the hint that scholars can plan, accomplish and measure their schooling (Palis and Quiros 2014: 115).

Adult learning is the most recognised of these philosophies (Ross-Gordon 2011: 28; Goddu 2012: 170). Regardless of the variations amongst the numerous scholarship approaches, several areas of consensus are present. Ozuah (2005: 86), indicating a small number of examples: the importance of having unambiguous intentions and learning consequences, the expansion of understanding from easy to more tough and imperceptible, vigorous scholar contribution, and the result of firming up and response. Daily and Landis (2014: 2065) upholds that even though many philosophies exist to explain grown-up learning, Andragogy, as described by Malcolm Knowles, remains the most suitable.

2.2.2 Assumptions of andragogy

Mature learning literature proposes that mature scholars are self-reliant, learn better when there are existing problems and have an intellect or prerequisite to acquire valuable information (Applin, Williams, Day and Buro 2011: 130). The Grown-up Knowledge Philosophy or adult learning is grounded on the six suppositions below:

2.2.2.1 Self-reliance

Grown-ups are proficient to direct their learning (Knowles 1980: 58; Nikolova *et al.* 2013: 156), assume accountability resulting from their conduct, and struggle to have acquaintance obligatory to them (Kenner and Weinerman 2011: 88).

Paris and Quiros (2014: 116) argue that facilitators should support their grown up learners to become self-directed academics. These authors argued that mature learners accept accountability for their particular pronouncements and their lives and for that reason are proficient. For instance, as human beings grow, their conceptions transfer from a dependant character to independent character (Daily and Landis 2014: 2065).

2.2.2.2 Need to learn

This is the requirement to recognise the purpose of knowledge acquiring or the necessity to study. A grown person will become skilled when they are geared up (Knowles 1980: 58). A grown person has precise knowledge acquisition necessities created by their societal responsibilities and lifetime trials (Nikolova *et al.* 2013: 157). According to Daily and Landis (2014: 2065), a grown person requires understanding how knowledge acquisition shall be directed, how scholarship shall take place, and how relevant that module content is to their lives. The eagerness to study is meticulously linked to the development of responsibilities for their collective tasks and they need to distinguish why they need to learn something (Daily and Landis 2014: 2065). Mahan and Stein (2014: 141), argue that it is essential while training grown persons to distinguish their level of enthusiasm to study and their keenness to take responsibility for learning through creating objectives and goals for their learning.

2.2.2.3 Life experiences

A grown person acquires lessons from their life encounters (Knowles 1980: 58; Nikolova *et al.* 2013: 156). Mature learners possess a comprehensive complexity of involvement which functions as a major fundamental underpinning of the identity of self (Kenner and Weinerman 2011: 88). Boctor (2013: 97) avers that the facilitator in a learning environment involving grownups, is there to impact knowledge. He/she does not necessarily possess every information. The aforementioned author proposes that facilitators equip mature learners throughout the acquaintance attaining progression and anticipate them to assume an active role. Grown-up gains a developing reservoir of familiarities, that is a reserve for education (Daily and Landis 2014: 2065).

2.2.2.4 Task, problem or inquiry-centred

An adult learner is able to gain knowledge when learning is task, problem-based or inquiry-oriented (Knowles 1980: 58). A grown person needs to put into practice what they have learned - expertise and the procurement of information (Nikolova *et al.* 2013: 156). Crookes, Crookes and Walsh (2013: 242) argue that the

opinion that grown up pupil nurses require to be educated using a technique that puts more importance on the real-world usage of the facts that they mount up in every lecture theatre so that they can be more involved with the subject matter. Mature people acquire first-hand information, expertise and outlooks ethics offered in the context of their applicability to actual lifetime situations (Palis and Quiros 2014: 116). Grown-ups experience transformation and change from future applications (Daily and Landis 2014: 2065).

2.2.2.5 Motivation

Mature learners remain enthusiastic to learn by development, achievement, inquisitiveness and self-confidence (Knowles 1980: 58). Bector (2013: 96), states that facilitators must be encouraged to practice facilitation approaches, which sustain mature learners' inspiration to gain knowledge. Further, most powerful inspirations are inner, rather than outer (Daily and Landis 2014: 2065). Operational facilitator of grown persons constructs a learning milieu accommodating mature learners, thereby encouraging scholars to connect the subject matter in ways that result in creativity and proficiency development (Mahan and Stein 2014: 142).

2.3 BEST PRACTICES FOR TEACHING ADULTS

Currently, an enormous amount of empirical evidence suggests the necessity for approach modification in nursing instruction and the benefit of vigorously engaging scholars in the knowledge acquisition process. In response to these reforms, the responsibility of the nurse has evolved and stretched out such that caregivers now function in roles that extend beyond the long-established bedside nursing care (Miller 2013: 9).

In an investigation conducted by Ferozali (2011: 51), nurse educators admitted that mature students in their classes necessitate the need for adult learning approaches. Jointly, the themes from the above study include the nurse educator's awareness of the diversity of knowledge delivery approaches in the lecture theatre and the significance of formulating learning milieu to provide scholars with opportunities to take a more active role in learning by changing from a facilitator-centred to the learner-centred approach. Even when NEIs understand and support the use of learner-centred pedagogical techniques, they may not put into operation these practices in their classrooms for several reasons. Some of the factors identified were the size of the class, the instructors' self-confidence, undergraduate scholars' hindrance and time constrictions (Szelenyi, Denson, and Inkelas 2013: 4).

ose stoc (9 cted o o a et a 0 3 56) a gue t at g o up knowledge acquisition necessitates special facilitators, precise techniques and precise ways of life. Contemporary perceptions of grown-up knowledge indicate the duty of the facilitator does not include conveyance of understanding but to simplify scholarship and get involved in the reciprocal analysis. Mature learners' knowledge acquisition philosophy embraces that grown person study novel acquaintance and expertise efficiently. It suggests that since knowledge acquisition cannot be detached from the milieu in which it is operated, the greatest period to acquire information about anything is while the realistic is proximately used (Kassirer 2010: 1119). Grown-up scholarship philosophy hypothesises that scholarship is finest attained by repetitive planned experience to actual circumstances (Kaissirer 2010: 1118) in a genuine milieu (Postma and White 2015: 75).

Cornelius (2014: 2) reports that long-established pedagogical methods such as lectures promote passive learning. Group-based learning is a coaching and knowledge acquisition approach, which focuses on the learners and places responsibility and accountability for learning on the learner. Case-based learning is a pioneering education strategy for instruction and scholarship and it can be defined as a process that utilises cases in which scholars explore, identify problems, and health issues presented in a case and provide the best possible solutions for identified problems (Linda, Daniels, Fakude and Modeste 2014: 91). Barker *et al.* (2013: 1) stated that facts expertise is cumulative in NEIs as a technique of announcement and acquaintance distribution. This varies from straightforward web-based explorations to completely computer-based instruction curriculum.

Watson *et al.* (2009: 145) cautions that it is merely by the re-establishment of compassionate training that the status of nursing will be conserved. Macdonald (2007: 75) suggests that the conception or fundamentals of consideration would be exposed to an explicit perspective as the occurrence is multidimensional to be world-wide to the universal circumstances.

Mahan and Stein (2014: 142) report, seven key principles resulting from the annotations of investigators similar to Knowles (1970 cited in Mahan and stein 2014: 142) and Vella (2008 cited in Mahan and Stein 2014) who inspected the reactions of grown persons in scholarship circumstances, discovered their drives and considerations and witnessed the greatest actual scholarship settings for grown persons. Table 2.1 presents the seven principles to guide adult teaching.

Table 2.1: The summary of premises and practices in teaching adult learners

PREMISE	PRACTICE
Grown-ups carry their previous knowledge to the scholarship varied encounters; they are capable and equipped to function.	<p>Ask questions about their knowledge and information on the subject.</p> <p>Witness their understanding/ expertise.</p> <ul style="list-style-type: none"> • Pay attention to them - express their capability.
Grownups are answerable for their education. They elect to learn or not to learn.	<ul style="list-style-type: none"> • Coaching with a problem relevant to mature learners. • Usage of cases to demonstrate the significance of the problem.
Grown persons' desire to acquire knowledge and utilise it immediately. They desire to action new concepts instantly.	Proposal of collective problem-solving initiatives as part of the scholarship development. Propose techniques for innovative concepts to be utilised.
Grown-ups learn best when they integrate scholarship with their existence.	Have fully-grown learners do the work of learning.
Grown persons acquire knowledge best when they participate actively: drive, attachment emotions are important in the scholarship.	<ul style="list-style-type: none"> • Use combinations of the four knowledge acquisition responsibilities in teaching and learning approaches: • Inductive responsibilities: make clear current comprehension and topics with new subject information. • Input responsibilities: address new subject information/ responsibilities through dialogue, negotiation, creative thinking and replication. • Carrying outer rinds: use new ideas/expertise in a knowledge set in meaningful activities. • Incorporation duties: apply what has been well learnt to existence and work – often after the coaching/ knowledge acquisition action.
Mature people bring outlooks of the instructor to the encounter.	<ul style="list-style-type: none"> • Understand and comprehend the grown-up pupils 'requirements.
Grown persons learn to change progress and develop new expertise. The adult student should leave the learning encounter different for the effort	<ul style="list-style-type: none"> • Examine what learners have acquired from the knowledge acquisition activity. • Survey learners after the activities to evaluate information or new performance and knowledge attained.

Source: Mahan and Stein 2014: 143

Mature learners' doctrines are suitably acknowledged for the coaching of medical specialists (Cadorin, Suter, Dante, Williamson, Devetti and Palese 2012: 153). Sheppard *et al.* (2014: 147) argue that grown-up scholars acquire finesse by performance; they favour group deliberations, are self-driven and react well to innovative coaching and education approaches that inspire profound scholarship. Student-centred instruction incorporates the ideologies of the fully-grown learning philosophy to cultivate self-efficacy and enhance critical education expertise. Learner-centred coaching guides grown-up scholars to build comprehension using a collaborative, public milieu and assist mature learners with realising subject matter by using innovative thought processes and expression (Ellis 2016: 67).

According to Slavich and Zimbardo (2012: 586) in learner-centred education, facilitators take into consideration the learners' requirements, capabilities, eagerness and knowledge acquisition approach by enabling them to participate vigorously and put forward to them self-sufficiency and self-regulation over the learning outcome, education techniques and speed of learning. Therefore, it inspires mature learners compelling education obligation and attaining expertise to accomplish education objectives (Slavich and Zimbardo 2012: 586). Learner-centred coaching and knowledge acquisition approaches comprise class discussions, acting out, class demonstrations, contemplative journals, case-based education, deliberations, turn over classroom, class undertakings and information-gathering (Ellis 2016: 67; Slavich and Zimbardo 2012: 586).

Caregiver education and training in South Africa have transformed radically over the past century, with the result that health care front-runners are conveying the necessity for the qualifying caregiver to acquire decisive thoughts to empower these neophytes to offer harmless and efficient healthcare to their clients (Nabors 2012: 1; Roof 2012: 2). Typically, long-established nursing instruction practices have not led to the acquirement of advanced judgment abilities. Traditional instructional strategies continue to dwell in prevalence in the nursing classroom, with the facilitator being the

primary format for instruction (Nabors 2012: 1). The current emphasis on teacher-centred learning and heavy content has been identified as approaches having limited effectiveness in accommodating diverse learners (Colley 2011: 2). Fürst (2011: 1) states that the continued use of traditional teacher-centred approaches rather than the application of more innovative student-centred approaches in nursing education is a major problem, as it interferes with the ability to cultivate critical thinking expertise in learner nurses.

The instructive methodology in all the medical professions was mostly lecturer-centred at the beginning of the 21st century as demonstrated by the usage of antiquated coaching methodologies like talks, debates and conferences. Nevertheless, as the centuries passed gradually, instructors commenced practising additional learner-oriented instruction approaches such as class effort, communal erudition, role-plays, and case discussions (Waltz, Jenkins and Han 2014: 392). Instructors found inadequate confirmation concerning the usage and efficiency of vigorous scholarship in medical occupations. McKee and Billman (2011: 21) propose facilitators are less-equipped to practice extended learner-centred instruction strategies. Consequently, they resort to schooling the learner nurses the way they were trained. This is often through the lecture method, memorisation quizzes and examinations.

In a study concerning nursing learning transformation in South Africa, Rispel and Bruce (2015: 119) established gaps in the construction blocks based on the countrywide principles on official approval, directive and recommendation, curricula and faculty. This study articulated apprehension about the reduced value of training and knowledge acquisition, obsolete curricula that are uncaring to the inhabitants and a shortage of facilitator readiness. According to Miller (2013: 27), predictable pedagogy stresses the use of regurgitation of knowledge and recollect, rather than developing decisive judgements in learners. According to Mulaudzi and Chyun (2015: 21) in tertiary institutions, it has become obvious that the application of knowledge needs to

accommodate digital learners. The learner is no longer expected to be a submissive absorber of knowledge (Wright 2011: 94).

According to Qamata-Mtshali (2012: 16), self-sufficient learning as a means or education approach results in scholars taking control of their wisdom and self-direction through official or unofficial settings to attain set aims or outcomes. The construction of new information does not occur passively, it necessitates vigorous participation, involvement and authentic dedication. Knowledge construction remains predominantly similar to the concept of autonomous knowledge acquiring and positions prominence on the dynamic investigation, autonomy and uniqueness in creating connotation. New information is constructed based on the obtainable information that scholars bring to the tutorial room. Knowledge acquiring is a vigorous progression wherein the educators, are answerable for constructing an atmosphere favourable to the creation of the learner's acquaintance expertise (Qamata-Mtshali 2012: 16).

Shellenbarger and Robb (2015: 79), argue that learner nurses must form part of the information growth in which academic and experiential learning is incorporated, for the reason that herein they realise how to achieve multifaceted experimental cases excellently. Benner, Hughes and Molly (2016: 6), state that nurse educators require to be empowered and revitalised to educate successfully, giving regard to the interrelation of theory into practice. Getting the experimental setting near the lecture theatre is essential to link the gaps that exist as far as the interrelation of theory and practice is concerned (Gazarian and Pennington 2012: 215). Long-established nursing core curriculums are well-thought-out by theoretical coaching wherein learners are assigned to study enormous amounts of content often utilising PowerPoint lectures. Facilitators are thrown down the gauntlet to involve scholars with authenticities to encourage thoughtfulness (Fahlberg, Rice, Muchrer and Brey 2014: 85-86). Old fashioned teaching approaches result in uninterested and less motivated learners (Shellenbarger and Robb 2015: 80).

A compassion-centred prospectus intends to offer scholars with an inclusive understanding of compassion so that they will be capable to render holistic care to another human being as caregivers (Zamanzadeh, Valizadeh, Azimzadeh, Aminaie, and Yousefzadeh 2014). Increasing affirmation proposes that nursing instruction has an integral impression on learner nurses' caring behaviours and that caring and nurturing teaching behaviours' have a significant influence on knowledge acquisition. According to Ferozali (2011: 2), the coaching of a content overloaded curriculum creates a predicament for facilitators in implementing diverse facilitation approaches to learners in the learning milieu. Therefore, to complete the subject outcomes most nurse educators are influenced by the long-established lecture technique, which results in learner nurses being frustrated and besieged with a volume of content they must become skilful at (Ndawo 2015: 104). Nursing education must expedite the use of new pedagogies that can improve scholar knowledge acquisition and accomplishment in these demanding times. As a result, nursing education must seek innovative teaching strategies to prepare scholars to function successfully in the healthcare system (Ellis 2013: 1).

Botma *et al.* (2014: 21), argues that learner nurses have to be lifetime students who are involved in deep-thought exercises, self-appraisal, self-sufficiency and who can manufacture information, relate acquaintance and rationale. Hence, the researcher thinks that nurse facilitators must utilise innovative coaching and scholarship tactics grounded on the ideologies of andragogy to encourage the expansion of the human caring attributes amongst the nursing learners.

2.4 THE CONCEPT OF CARING IN NURSING EDUCATION

Jooste (2018: 25-26) argues that the nursing profession came into existence because of the requirement to be kind-hearted to others. To be a caring individual, one has to realise and accept that meeting the needs of others often take dominance over the self, especially when caring for vulnerable people. A caring caregiver behaves in a sympathetic, dedicated, reliable,

convincing and proficient manner. These characteristics are acquired by internalising all the relevant nursing ethical principles and are acted out to the benefit of the client, the individual nurse, the nursing fraternity at large, the public and the realm in which the nurse works (Jooste 2018: 25-26).

Watson (2005) declares that the practice of caring is the foundation of a nursing career. Watson's suppositions are as follows:

- Human caring is not just a passion or desire, caring implies an individual reaction.
- Caring is a reciprocal human process and is the ethical model of the nursing profession.
- Compassion can be successfully portrayed interpersonally.
- Successful compassion enhances healthiness of a human being or relatives' development.
- Sympathetic caring enhances healthiness more than does medicinal.
- Compassionate reactions recognize someone, not as they present themselves currently, nevertheless likewise for future or what they may become.
- Therapeutic milieu gives the enhancement of likelihood although permitting the individual to select the greatest achievement for the person during that period.
- Compassionate circumstances comprise accomplishment and excellence through the caregiver and the care receiver. Compassionate attainment is subjective, the restrictions of ingenuousness magnify over and above hominid dimensions.
- The greatest non-concrete distinctive of a compassionate creature is that the individual is in some way approachable to a different somebody as an exclusive singular, distinguishes the former persons' emotional state, and selects some human being apart from the alternative individual.

- Human compassionate encompasses philosophies, a determination and a responsibility to show concern, information, compassionate activities and outcomes.
- The perfect and worth of compassion is a point of departure, a standpoint and an outlook that has developed a backbone, an intent, an obligation and a cognisant verdict that demonstrates the aforementioned in tangible performances.

Watson (1991; 2002; 2008) emphasises the significance of a compassion instance or instant the minute the caregiver and the client collaborate to an extent that an occurrence for human compassion is established. Considerate instants might not be restricted only to the caregiver-client interface, however, they may perhaps also transpire in the course of NEI and learner nurse cooperation. The reciprocal and mutual connection amongst NEI and learner empowers the learner nurse to look for a connotation or completeness and develop as a caring individual (Sawatzky, Enns, Ashcroft, Davis, and Harder 2009; Wade and Kasper 2006). Constructing nursing instruction an idyllic domicile to inspire and cultivate learner nurse compassionate for the reason that this is where the subjective connection with others occurs (McEnroe-Petitte 2014; Khademian and Vizeshfar 2008; Wade and Kasper 2006).

2.5 LITERATURE SEARCH IN THE PROCESS OF IMPROVEMENT OF THE THERAPEUTIC NURSE PATIENT RELATIONSHIP (NPR)

Compassion, faith, communiqué, paying attention, coaching, and education in the establishing of the curative caregiver client association is identified by authors as conceptions that can be hindrances or enhancers in the business of therapeutic caregiver client affiliation.

2.5.1 Founding credulous caregiver-care receiver association (NPR)

There is a concurrence amongst most investigators that reliance remains the foundation stone in the institution of the curative caregiver-client connection. However, faith is not noticeably comprehended equally by the caregiver and

the client within the health-giving milieu (Dowling 2008: 319-328; Dziopa and Ahern 2009: 1-12 and Scott, Cohen, DiGcco-Bloom, Miller, Stanger and Crabtree 2008: 320). Belcher and Jones (2009: 142-152), investigated the views of registered nurses on their encounters in forming dependence in the experiential learning milieu. This investigation acknowledged that the character attributes of persons, the internal drive of the caregiver to assist human beings are the fundamentals to create the curative-caregiver client association. The fundamentals state clearly that there are no two personalities that will magnificently institute the curative association with the same client. These investigators also state that in the progression of nurturing the association, the skill of constructing an understanding is grounded on the duty of the caregiver to offer and the client to obtain healthcare services (Belcher and Jones 2009: 142-152).

Berg and Danielson (2007: 500-506) in the investigation of discovering the confidence as the perplexing insight interrogated the qualified caregivers that pointed out that one can cultivate faith provided one has sufficient time to spend with the client. Macdonald (2007: 74), Pearcey (2010: 52) and Ward, Cody, Schaal and Hojat (2012: 35) affirm that phase is the dominant characteristic, given the context in which the investigations were carried out (healthcare institution). However, the findings that “time” is insufficient in the healthcare institutions is inadequate in the hospital situation as the patients are in the ward for 24hrs. Time, as a result, is problematic in surroundings such as casualty sections and the Primary Health Care (PHC) contexts in which the caregivers have restricted time to spend with clients.

Berg and Danielson (2007: 500-506) and Belcher and Jones (2009: 142-152) argues that, the usage of the cumulative system is also a flaw of the investigation as acknowledged by the writers in the restrictions of the investigation. It is renowned that the Vivo estimate from the research investigations lacked the clients’ viewpoint of the creation of the credulous association. The strong point of the aforementioned investigations, on the other hand, recognised that the creation of the credulous association may not

be ascribed to the solitary attributes, however likewise comprises the ecological features, linguistic obstructions, and information and expertise of caregivers and the former encounters of the clients. As of the evaluation, it is unclear in what manner either the caregivers or the client recognises that the association is curative or not. Faith is recognisable as the substantial characteristic in the expansion of the curative association. The confidence ought to be mutual in both the caregiver and the care receiver for it to be successful (College of Nurses of Ontario 2009: 3). If faith is damaged, the affiliation will break down and be irreparable. Betham (2011: 33) suggests that additional investigations to discover the progression of the establishment of faith are crucial. An overall hypothesis that long-standing collaboration with the client will ultimately consequence in the credulous association exists.

According to Berg and Danielson (2007: 501), faith might not improve after an elongated caregiver client collaboration. Morgan and Moffatt (2008: 342) queried whether the caregiver's care for the association is worsened because caregivers automatically have no faith in what clients tell them. Van Rooyen, Le Roux and Kotze (2008: 22) state that caregivers who work with terminally ill cancer patients have a decent connection with their clients. This may be because cancer caregivers spend long periods with their clients. Oncology nurses deal with the mental state (subjective, client and significant others) and they engross the clients' companion's vigorously in the nursing intervention of such clients. However, according to Camille (2010: 27), the period is not the defining feature in the connection but the expertise of the expert such as paying attention. The aforementioned author reacts to the growing grievances associated to the duty of computers in the operational setting in which caregivers are spending maximum time on machinery (laptops) and not interconnecting directly with clients (Camille (2010: 27).

Pross, Boykin, Hilton, Gabuat (2010: 142-147) conducted a diversified technique investigation with 285 registered nurses partaking. These investigators utilised the research instrument that was previously confirmed for legitimacy and dependability. Investigation outcomes substantiated

through the single-mindedness cluster deliberations, narrative and dialogues recognised dissimilar conceptions that govern the actual associations. The investigation highlights that the first ten minutes of interface amongst caregivers and clients regulates the consequences of the connection. The information, bravery and endurance were described as topics in the investigation, entirely the three were interconnected to the listening skills of the caregiver and the sentiment from the client being attended to.

2.5.2 Communication and listening as the determining factor of caregiver client association

Listening is unanimously acknowledged as the determining factor of the curative association (Scott *et al.* 2008: 320; College of Nurses of Orlando 2009: 3). The quantifiable investigation among the 103 caregivers to amount their grade of proficiencies concerning the influential, interactive and simulated expertise in the course of their interface with clients (Babler-Schrader and Babler (2011: 370-375). The interactive abilities explored the frequencies of practicing behaviours such as rapport, establishing confidence, attending and communicating meritoriously. Of the 590 declarations that were produced from the theme exploration, only 14 were connected with the listening and communication skills. It is apparent that regardless of the importance of communication and listening they are not effective performances in the day-to-day communication with clients and their relatives.

Listening is linked with qualities, for instance, reflecting, probing or fact-finding and sustained eye contact or unexpressed gestures to confirm that the caregiver is paying attention (Dziopa and Ahern 2009: 3). Listening to clients, adopts a broad-minded approach, part of the understanding with the client and provides complete consideration as this will be the reason the client feels that he is of worth to the caregivers and the caregivers are interested in him (Scott, Cohen, DiGcco-Bloom, Miller, Stanger, and Crabtree 2008: 320).

Scott *et al.* (2008: 315-322) stated that confidence is the outcome of the accurately originated association, not the foundation of a prosperous affiliation. The investigation displays that there are progressions with the dependence consequence: appreciating the client by displaying the non-judgemental approach, genuine existence, and attaching with the client. The gratitude of supremacy, caregivers imparts the information to the client within their level of knowledge. The capability to demonstrate obligation to the affiliation by offering the engagements that are related to compassionate (eye interaction, amused, appropriate touch etc.). Aforementioned actions can be a recognised condition that the healthcare provider is collaborating and attending efficiently. These investigators concluded that the development of emergent doctor-client therapeutic affiliation, this study was suggested to be universal to all other contexts. It cannot be presumed that listening skill originates naturally for care providers (Scott *et al.* 2008: 315-322). According to Brunero and Lamont (2010: 136-146), the self-assurance of caregivers in their listening capabilities and appreciated that irrespective of the training prospectus that the caregiver was undertaking during their pre-registration course, the self-assurance and listening are trivial.

2.5.3 Proving sympathy in the curative caregiver-client association

Compassion as perception remained well thought out as the determining factor of listening and communication skills. One of the most important attributes of a caregiver should be the ability to be responsive, both physically and emotionally. The caregiver must not only apply his knowledge to a given situation, but he should also seek to understand the client's perceptions. Responsiveness permits the caregiver to interconnect in a transmission manner to acknowledge the clients' desires and apprehensions. Sympathy comprises the kind-heartedness towards the clients' circumstances. The caregiver should always be unprejudiced and respond compassionately. The caregiver should also inspire confidence in the client, and provide substantial information that will be indicative of ability and expertise in managing the situation (Watson 2008: 82). The 214 qualified caregivers were conscripted

from the initial level to the last level of study. The trustworthiness instrument of the Jefferson scale of clinician compassion was utilised in their investigation. Their investigation showed that as the caregivers advance in their career there is confirmation of a diminishing sympathy (Ward, Cody, Schaal and Hojat 2012: 34-40). Meanwhile, Dowling (2008: 319-328) and Halldorsdottir (2008: 643-642) stated that as the caregivers are upgrading their studies and become well-informed in their career, the standard of caring improves.

The additional influential feature to the deterioration of kind-heartedness is interrelated with the deficiency of records from the managers and administrators in the CLE. From the viewpoint of caregivers, the ecological dynamics are significant in the development of the healing (Ward *et al.* (2012: 34-40). According to Martensson (2010), ecological issues and career fulfilment level determine the human caring abilities of the caregivers.

Irrespective of the transformation in the approaches utilised to quantify caring from diverse investigations revised, the methodologies proposed and suppositions give the impression not to offer explanations to progress the compassion amongst the caregivers. The investigations carried out continue to highlight the major factors that contribute to a decline in caring practice. There are several literature review studies, which explored the determinants of the formation of the therapeutic relationship, and instead the results added the list of factors that impedes the formation of an effective therapeutic relationship (Macdonald 2007; Pearcey 2010 and Dziopa and Ahern 2009: 7). The research investigations commended that authors have a duty to endure to sharpen up the fundamentals of compassion which were prepared in the nursing fraternity by discovering the compassion performances in the administration of clients with chronic pain (Dziopa and Ahern 2009: 7).

Dziopa and Ahern (2009: 7) evaluated the contributing factor of the calibre of the therapeutic relationship by conducting the literature search. The insertion of the critique founded on the substantiated-foundation enhances the integrity

of the nursing fraternity. Thirty-one investigations incorporated in the re-evaluation presented a sufficient illustration to permit the scrutiny of the creation necessary to exhibit the curative association. The hypotheses acknowledged in the investigation vicinity are (i) Appreciative and compassion (ii) Uniqueness (iii) Giving assistance (iv) Attendance (v) Authenticity (vi) Endorsing impartiality (vii) Signifying admiration (viii) Indicating unambiguous margins (ix) Signifying self-understanding. The afore-mentioned investigation's framework centres around the therapeutic relationship for the mentally ill patients but the constructs identified relates to the ten Caritas processes identified by the Watson human caring theory which did not receive a specific context of care (Watson 2008: 82).

Consequences of the investigation revealed that caregivers are caretakers instituting healing association. Caregivers and clients must profit similarly from the association. Paradigms, for instance, admiration, appreciative and fairness are illustrations of the joint abilities in the formation of the healing association. The hypotheses such as high regard, appreciative and equivalence are models of the mutual abilities in the founding of the healing association. Each hypothesis in the consequences of the investigations pointed out compassion actions confirms comprehension of quality of healing association. The one construct that the author also acknowledged that there are no clear practices to display in the caring relationship relates to the presentation of the self-awareness of the therapist. The drawn image of the hypotheses indicates that the hypotheses do not comprise of priority order however, they are obligatory according to the separate condition of the relationship or association. Outcomes indicated that the execution of the considerate activities to accomplish the excellence healing association necessitates the understanding and the expansion of the instruction and training.

2.5.4 The coaching and scholarship of the caregiver-client relationship

Teaching practices in the NEI's must prepare learners for communications capabilities so that they are capable to establish trusting relationships with clients. Restrictions of the investigations were insufficient sampling (seven nurses) and the specimen performances (cumulative), that enhance the prejudice of the outcomes.

Brunero and Lamont (2010: 1370) conducted action research with the same number of participants (seven nurses) to expose them to the role-play, experiential learning and some in-service experience through the e-learning package. They reported development in the confidence level of caregivers to create an association but not in any way indicated the success in implementing the healing affiliation. It may therefore, not be presumed that when the caregivers' self-assurance level is enhanced they are likely to succeed in forming the healing caregiver-client association. Watson *et al.* (2009: 145) argues that in the course of the re-establishment of the compassionate custom that the status of a nursing career will be reserved. The conception or essentials of compassion must be investigated in an explicit milieu as the occurrence is multifarious to be generalised to the broad-spectrum circumstances (Macdonald 2007: 75)

Beck (1991) argues that the concept of consideration in nursing instruction has been investigated and established deficient. If professor proficiency is crucial to the extension of consideration to learners, facilitators necessitate investigation on the topic of the coaching of kind-heartedness, founded on the outcome of investigation preferably than on the individual consideration viewpoint of the professor (Beck 1991). Facilitators must be equipped for their responsibility by learning the supposition of coaching that is suitable for the training of kind-heartedness. Essentials (e.g. coaching approaches, traits of consideration in nursing instruction) which may be integrated into the instruction of consideration have been acknowledged in this investigation the information-founded on the coaching of compassion to learner nurses ought

to be comprised of instructor manners, it should include the thinking process of instructors and undergraduates (Zeichner 1990: 3-20).

Compassion in learner-educator affairs is vital to nursing instruction for two major reasons. Firstly, learners must instrument kindness custom, it is required that nurse learners encounter compassion in their existence and in their learning milieu (Watson 1988; Diekelmann 1990; Brown 1991; Green-Hernandez 1991; Keen 1991; Miller 1991, Sheston 1991; Hughes 1992). Secondly, the enablement of scholars to deliberate judgmentally and for their personalities to necessitate a credulous and compassionate atmosphere (Watson 1990; Hedm and Donovan 1991). Numerous investigators questioned consideration as an attitude can and should be imparted to learner nurses (Romiszowski 1981; Jarvis 1984; Dawson 1992: 473-479). Dawson (1992: 473-479) affirmed that moral code of coaching kind-heartedness as a prescribed outlook to learner nurses must be interrogated, particularly if caring by learners is to be appraised. Condon (1992: 14-19) declares that consideration ought to be given by the care provider and the care receiver.

The American Association of Colleges of Nursing (1998; 2008) and the National League for Nursing (2007) acknowledged compassion as fundamental to the field under study. Efforts in nursing instruction to direct development of individual recognition as a compassionate human being with characteristics of compassion. Consideration is essential for the advancement of decisive judgment (Benner 2000; Benner, Tanner, and Chelsa 2009 and Benner and Wrubel 1989).

According to Falk-Raphael (1996: 3-17), compassion in this field is developed from a well-organised (necessary) kindness (connected features), incorporate consideration (nursing career evolved sovereign career), progressed to an equipped consideration (caregivers comprehend nursing connections to upholding consideration associations) within an inter-professional healthiness provision arrangement. This researcher recommends that enhanced kindness is well-versed information and understanding. According to Roach (2002: 39),

kind-heartedness is a decisive factor in living beings that can give significance to one's existence.

Adamski, Parsons and Hooper (2009: 361) argues that it would be helpful to integrate a caring colloquium or class into the nursing programme to help learners memorise the essential idea of caring. They also state that experimental caregivers are an important source in assisting learner nurses to adjust and become accustomed to their responsibilities. Caregivers can replenish their dedication to kind-heartedness as a core principle for this profession.

Labrague, McEnroe-Petitte, Papathanassiou, and Arulappan (2015), maintain that tutors' caring behaviours influence learner nurses' caring behaviours positively. Nursing instruction guidance intends to support learner nurses to general scrutiny of caring discipline so that they are competent to develop as compassionate persons. Prospectus for nurses must integrate instruction approach based on the philosophy of compassion, which stimulates caring principles in undergraduates. Scholars' appointment in studying consideration may be fostered through inventive instruction approaches for example imitations, instructive entertainments, and case-based learning may well be discovered. Facilitators may oblige learners to construct written reviews, nursing care strategies, and circumstantial documentation signifying compassion delivered by them and collective self-appraisal on the incorporation of compassionate performances for the duration of experiential learning (Labrague *et al.* 2015).

Assisting learner nurses (or other professionals) at advanced stages of helpfulness is not an insignificant mission (Eskilsson, Herbreg and Ekebergh *et al.* 2014). Facilitators necessitate an obvious and dependable comprehension of what caring is; what expertise and capabilities are desirable to be efficacious at compassion; and how to guarantee undergraduates study to be efficient at it. Initial constituents for caring that are obligatory by nowadays' undergraduates comprise resilient communiqué and association

expertise (Betcher 2010: 101-105). Unfortunately, not all learner nurses qualify with the aforementioned attributes. Evaluation of learner caregivers' kind-heartedness by clients showed only modest stages of caring (Labrague 2014: 105-113). Disturbingly, there is a confirmation to specify that some learner nurses' stages of consideration deteriorated whilst they were registered in the nurse training course (Murphy, Jones, Edwards *et al.* 2009) and may also be found to be lower among older learners (Nadelson 2010: 59-73).

Porr and Egan (2013: 35-43) argue that for facilitators to display compassion for learners, they should experience consideration and be appreciated by their contemporaries, academics and administrators. The type of consideration in nurse instruction has concentrated on the distinct educator instead of compassion within NEI.

Beck (2001: 320-322) assessed the duty of the NEI caring for learners as a significant requirement for learner nurses' knowledge to show concern for healthcare users. This investigation exposed five descriptions or subjects that saturated consideration in nurse schooling. These themes centred on a shared association that comprised of presenting, involvement, sustaining, proficiency and inspiring outcomes of compassion. Insinuations of this meta-synthesis for facilitators were explored in their research. Cook and Cullen (2003: 192-197) defined determinations to interlace the perception of consideration through undergraduate nursing degree prospectus documented that responsibility demonstrating and supporting had a foremost influence on learner nurses' tolerant, comprehending, and confessing the necessity for compassion in the tending career.

According to Nelms, Jones, and Gray (1993: 18-23), scholars learn caring not only from capability role modelling, both in the theoretical and in the clinical context, but also by observing clinicians in the clinical setting. Watson (2009: 270) specifies that if compassion is not investigated sufficiently to update the professional training, the nursing career will be endangered and those who

will be continuing in this fraternity will develop toughened and unresponsive attitudes to clients.

According to Noddings (1984), there are four dominant mechanisms in coaching compassion. These comprise (a) modelling, pronounced as an expression of caring to learner nurses for them to attain information of how to display caring; (b) conversation, which comprises an authentic unlimited interchange and discussed behaviour that displays compassion; (c) occasion to drill consideration; and (d) corroboration or response to the considerate instance. Numerous authors concur that kind-heartedness is mastered by feeling kind-hearted associations with the NEI in an atmosphere sustained by optimistic considerate NEI–learner nurse associations (Eley, Eley, Bertello, and Rogers-Clark 2012: 1546-1555; Gaines and Baldwin 1996: 124-128; Tanner 1990: 70-72; Watson 2008: 82).

Learner nurses are expected to submit to professional grooming so that they are able to internalise the moral ideologies, attitudes and honourable code of conduct of the nursing career (Mashaba and Brink 1994: 310). Forrest (1989: 815-823) cites that the facilitators' demonstrating of compassion is an influential means of encouraging learners to adopt caring practices and approaches in their practice. Jones and Gray (cited in Nelms *et al.* 1993) maintain that the interviews with nurse educators showed that caring as a nurse is learnt from NEI role models. Nelms *et al.* (1993), affirm that scholars become skilled at caring from those persons, for example, health care staff other than nurse educators. These authors concluded that nurse scholars gain knowledge on how to display compassion as carers in their interpretation of both caring and uncaring practices.

The Department of Health (2013: 35) confirms that the main purpose of tending instruction and preparation is to offer sufficient statistics of skilful, compassionate care providers to gratify the healthiness desires of the society. education and training activities and initiatives must be coordinated with health service delivery needs while ensuring that qualifications obtained

correspond with the scope of practice and appropriate legislation. Nursing education transformation must comprise a robust association amongst the HEI and other suitable role-players to ensure success. Nursing education and training should be a national proficiency accounting to the Director-General of Health. Nursing training modification needs to address the following:

- A huge amount of diverse professional designations of caregivers trained in the realm.
- Excellence and application of professional caregivers to achieve advances in the health of populations.
- Health system needs to validate that qualifications are commensurate with scopes of practice.
- Hindrance of coaching platforms (excellence of clinical placement areas and administration/ executive) dimensions and excellence of NEI's (Department of Health 2013: 35).

Diekelmann (1990) and Paterson (1991) both argued that more investigations are essential to decide by what means the learner and proficient facilitators diverge in their understanding of compassion in care training. Caring in nursing education subsumes similar caring attributes as the care of patients. It is obvious that nurse educators educate out of their experience as caregivers (Diekelmann 1990; Paterson 1991), the implications of this has received little deliberation. Can nurse facilitators offer lessons about caring efficiently to learner nurses, if they do not have the expertise as caregivers? Is kind-heartedness as a caregiver continuously tantamount to compassion as a nurse educator? Are the same techniques engaged to convey consideration to clients and learners? How does a nurse lecturer manage situations in which both the client and the learner nurse equally necessitate consideration? The identified constraints to caring have been detailed in their research. An elementary worth of the nursing occupation, it is alleged that learner compassion can be refined, imparted, and evaluated utilising tending training and, as soon as presented early, modelled and armour-plated during the prospectus (Alpers, Jarrell, and Wotring 2013: 68-69).

Through positive NEI demonstrating and role displaying, learner nurses may be trained to advance the proficiency of compassion (McEnroe-Petitte 2014). In addition, when the climate of nursing education is perceived as caring, scholars acquire a proficient manner of actuality and gain knowledge of how to display compassion as a registered caregiver (Beck 2001; Kelly 2007; Labrague 2012; Woodrow 2003).

2.6 CARING BEHAVIOUR AND PATIENT OUTCOMES

There are limited studies that examine nursing care activities to client result, although investigations are growing regarding the benefits of assured interferences like nursing assessment and diagnosis (Muller-Staub *et al.* 2006: 514-531). The caregivers' roles involve the duty of meeting the health care of individual clients. This main task of caregivers can be achieved by proper execution and application of the nursing process. The nursing process is both theoretical and practical, and it also offers a structure within which caregivers can apply their expertise to express human caring autonomously (Lofmark and Thorell-Ekstrand 2004: 291-298). The nursing process has become the benchmark for providing efficient nursing care globally, although many think that it is time-consuming (Ting-Ting 2005: 640-648). Neglecting the nursing process means that caregivers may carry on to get involved in standard nursing skills on the foundation of medicinal diagnoses instead of the justification based on nursing assessment, nursing diagnoses, planning, evaluation, record keeping and feedback. The query may be in what manner caregivers postulate answerability and culpability for clients and in what way the excellence of nursing compassion might be assessed if the nursing process is not utilised (Mutshatshi, Mamogobo and Mothiba 2015: 445-455).

Studies in the US have revealed a link between scarce hospital treatment employment and an augmented hazard of undesirable healthcare user results, comprising deaths (Buehaus, Donelan, Ulrich, Norman, DesPoches and Dittus 2007: 853-862). Lengthy operational times and overtime together with 'have second jobs' result to a sleep deficit, overtiredness and occupation

anxiety. In addition, a worn-out caregiver heightens the possibility of medical malpractice, thus declining the excellence of client compassion (Shipman 2008). Figures issued by the World Health Organization have discovered great discrepancies amongst countries concerning the magnitude of doctors and nurses' /midwifery personnel per 10 000 populaces. The number for South Africa are 8 physicians and 41 tending and maternity employees per 10 000 populaces. Concerning legal action, it is well tolerable that the index of curative treatment will be impacted as burdens on the healthcare structure increase. This is particularly true in the state sector in South Africa at present, but it also applies to the private sector (Pepper and Slabbert 2011: 34). Motsoaledi (2015: 1) argues that lawsuit dues in the Republic have increased, with warning that the care-based practice of medicine is being replaced by defensive medicine and distrust.

The nursing career requires caring personalities. Graduating individuals who interrelate with other human beings in a sympathetic and considerate fashion is obligatory for a nursing career to preserve the appearance of being a compassionate career. Having compassionate, caring or hard-hearted and uncaring nurses also has a financial influence on the healthcare sector (Nadelson, Zigmoid, Nadelson, Scaden and Collins 2016: 7). Pepper and Slabbert (2011: 29) affirm that South Africa is witnessing a high-pitched escalation in therapeutic negligence lawsuit as clients progressively turn out to be cognisant of their privileges in an environment of minute resources. The consequences of increased litigation are: (i) a further reduction in the country's ability to finance health care because of large pay-outs; and (ii) a continuing increase in malpractice premiums in the private sector.

According to Dhlomo (2017), KZN Department of Health is projected to reimburse R241 million for a lawsuit in 2018. In 2017, it was stated that this department was defending litigations amounting to approximately R10 billion. According to Mhlongo, Sibiyi and Miya (2016: 162-178) below average care has a destructive influence on both the client and the Department of Health. These investigators directed a research study to determine and describe the

experiences of midwives regarding practice breakdown in maternity units at a public hospital in KZN in order to improve the quality of care in maternity units. These investigators conducted qualitative research that was investigative, descriptive and circumstantial. Partially organised dialogues were conducted with 13 midwives. The investigator exposed that the mainstream of the subjects confronted practise interruption, which typically begins for the duration of the prenatal care appointments. Midwives who offered services to pregnant women did not adhere to established etiquettes and guiding principle and this resulted in difficulties in childbirth. These participants expressed their view that the administrators were less concerned about their difficulties and did not endeavour to solve them (Mhlongo, Sibiya and Miya 2016: 162-178).

Healthcare in South Africa is in a condition of instability. The modification in prominence from health centre-focussed services to PHC and the establishment of the DHS are both upsetting the manner wherein healthcare is delivered. Caregivers, who are pillars in the quest for sustainable and efficient healthcare delivery will be required to partake in carrying out this transformation. Nurse training, for that reason, need to be modified to equip caregivers for the setting wherein they will work. Innovative viewpoints in nurse schooling, which highlight the learner as active rather than passive in the scholarship are infiltrating instructive institutions (Mekwa 2000: 271).

In South Africa, as in numerous states globally, healthcare services are delivered by an array of specialists, whereas caregivers form the moral fibre of any preventive medicine structure (Jooste and Jasper 2012: 56-64). The significant all-encompassing approach utilised efficiently globally to tackle numerous challenges is creating positive practice environments (PPE) (Department of Health 2013: 48). Learner nurses must be able to function efficiently within a rapidly changing and potentially demanding atmosphere in the diverse theoretical and practical environment. Scholars must be able to interrelate considerately with others, including clients, significant others, NEI,

other learners and members of the multidisciplinary team, from miscellaneous social, emotional, cultural and intellectual surroundings.

According to Jooste (2018: 247-248), client protection and excellence of services are everyday concerns for caregivers due to augmented information of health matters on the part of clients. In South Africa, the introduction of the Bathopele Principles has also positioned greater prominence on clients' rights. Clinical leaders, therefore, require acquiring a range of expertise and involvements that they may apply to inspire and involve multidisciplinary staffs in hazard valuation and unceasing excellence enhancement in all stages of client service provision delivery. Clinical leaders should have a range of skills and interventions to motivate and engage clinical teams in risk assessment and continue quality improvement at all levels of client care delivery (Jooste 2018: 247-248).

Nursing and midwifery are recognised as compassionate careers, which are reliant on proficient information and expertise. Caregivers ought to be proficient to render circumspection to clients and are eligible for suitable reimbursement, profits and the privilege to operate in a setting in which they can render excellent healthcare amenities. State of affairs, particularly in the civic healthcare institutions, has not been accommodating of excellence provision distribution; equally, community, sequestered subdivisions, misuse, and harassment have led to burnout and extraordinary throughput amid clinician nursing personnel. The investigation has established that remunerations are not the chief inspiration upsetting the enthusiasm of caregivers. Absence of confidence was documented as discouraging and associated with hard-hearted behaviour in the direction of clients. The non-existence of administrative expertise and the postponement in executing CPD supplementary aggravate these encounters (Department of Health 2013: 28).

There has been a stable weakening in official, nursing governance posts at nationwide and regional healthcare facility associations in South Africa with development in other specialists not related to nursing in governance and

administration situations. The aforementioned administration tactic has unintentionally led to a loss direction and deteriorating self-confidence and morale of caregivers and midwifery (Department of Health 2013: 27). In addition, it is significant to scrutinise by what means the restrictions of the operational environment, for example, high nursing workloads and declining period for caregiver-client collaboration, disrupt the caring attributes of caregivers. Thus, nursing education is required to produce genuine and reachable resolutions to problems and offer support to the professional identity and growth of learners (Ousey and Johnson 2007).

Guiding principles regarding the number of caregivers that ought to be engaged in a healthcare organisation are needed in order to provide clients with professional and efficient treatment. Customarily inhabitants' centred standards were utilised to govern this. World Health Organisation (WHO) now differentiates that hands-on ethics might remain a functioning skill of decisive recruitment requirements for wellbeing, as they account for number of clients, types and location of services that determine the number of caregivers and the expertise mix required. Caregivers to client relation eventually regulate the caregivers' amount of work, job gratification and the efficiency of looking after, and compares with mortality rates in health institutions and additional caregivers' sensitive indicators. The Ministerial Task Team (MTT) recommends that South Africa embraces a mixture of inhabitants centred standards and WHO performance-founded assignment tactic to regulate safe staffing standards (Department of Health 2013: 28).

Gratification in personnel and the self-assurance to interrelate as an equivalent with added specialists is meticulously connected to self-confidence or one's determination. The matter of self-assurance in healthcare professionals has not remained broadly investigated notwithstanding commendations that efficient medical frontrunners are those who inspire the ethical-enhancing potentials of compassion, sustenance and equilibrium in their employees to inspire retaining and emotional state of staff (Pearcey and Elliott 2004). The Department of Health affirms that in South Africa nursing

lack of adequate staffing, impracticable amount of work, inadequately equipped healthcare centres, hazardous operational circumstances and apparent unjust reimbursement are amongst the aspects upsetting the employment and efficacy of caregivers and midwives and other preventive medicine specialists and preventive medicine personnel. The aforementioned jeopardises excellent client care, but also the eminence of integration of theory into practice and clinical experience for learner nurses, midwives and all other wellness programme professionals. Positive Practice Environments (PPE) is cost-effective healthcare settings that support nursing excellence and has the ability to attract and retain staff and to improve patient satisfaction, safety and outcomes (Department of Health 2013: 27).

There is a high attrition rate of caregivers who effectively completed their instructive prospectus per annum and individuals enrolled with the SANC. The attrition rate of caregivers who finalised their schooling however, do not register is approximately forty percent. Output (number of caregivers that come in training and become licensed) is unceremoniously projected at around fifty percent however, necessitates exploration. A projected eighteen percent of caregivers on the SANC roll are not vigorously operating. While the number of nurses per 100 000 populations is favourable, the mix of nursing categories is skewed, with a significant decrease in the ratio of Registered Nurses (RNs). Professional caregivers encompass only sixteen percent of newly qualified carers enrolling and are projected to deteriorate from fifty percent in 2009 to thirty-seven percent in 2020. Professional caregivers are senior to the subcategory classifications with 43.7% being above age fifty and retire at a frequency of 3000 per annum for the subsequent 10-15 years. Training and retaining RNs needs urgent attention based on the need to enhance skills and healthcare access with the introduction of NHI and the re-engineering of PHC. The trend internationally is to develop and train all nurses at degree phase (Department of Health 2013: 30).

The scarce distribution of qualified caregivers presents an enormous challenge to service delivery. Discrepancies in nursing education with the termination and the successful unification of NEIs instigated a deterioration in the quantity of all-inclusively qualified registered caregivers. Furthermore, secluded NEIs are similarly training an enormous quantity of staff nurses and enrolled in nursing auxiliaries who are most appropriate for metropolitan regions and are inadequately equipped for primary healthcare (PHC). There is a requirement to cultivate the appearance of nursing career and to uphold nursing as a profession of choice (Department of Health 2013: 42-43).

Important workplace components that strengthen and support staff and in turn have an influence on patient outcomes and organisational cost-effectiveness will assist in ensuring excellence in healthcare, the establishment and maintenance of an effective healthcare professional workforce and the quality of health practices. An amalgamation of neighbouring and worldwide guiding principles on positive practice environments (PPE) is essential to ensure an integrated quality nursing service within a value-based culture in line with Medium Term Strategic Framework 2009-2014 'A long and Healthy Life for all SA' and for the successful roll out of the National Health Insurance (NHI) in South Africa (Department of Health 2013: 48).

The issues relating to distinct caregivers, the association and administrators may well inspire the preservation of qualified caregivers. Deprived operational environment, lengthy and awkward operational periods, unreasonable reimbursement and restricted qualified advancement prospects for caregivers must be tackled. Improving the appearance of the nursing profession and generating a synchronised workstation in which multi-generational nurturing personnel senses appreciated drive to advance staff retention. Managerial issues that advance retaining ought to be recognised. Healthcare administrators observe healthcare institutions in which they operate as dangerous, and caregivers are prospective sufferers of viciousness and unlawful performances, wherein client wellbeing is endangered by an increase in medical errors, because of a deficiency of possessions and personnel

deficiencies. The organisational culture of each institution is instrumental in contributing to professional nurses' retention rates.

Policy makers in the country are cognisant of the scarcity of physicians, nurses and caregivers, particularly in rural areas. Policy responses have ranged from community service to increasing monetary incentives (Chabikuli and Schneider (2005). According to Reid (2005), a compulsory communal facility for physicians in underserved regions for a single year has subsequently increased the number of doctors in these areas. Nevertheless, approximately twenty-five percent of qualified physicians remained positioned in regional settings. These guidelines have been inadequate to talk about the opening in the production of the aforementioned classifications of personnel. Confirmation of ongoing undecorated inequities in the dissemination of healthiness employees amongst metropolitan and countryside surroundings proposes that supplementary processes might be mandatory in juxtaposition with the financial enticements (Barden-O' Fallon 2006: 80-90). Thailand has efficaciously succeeded in conglomerate budgetary enticements with non-financial enticements to maintain trained healthcare employees in rural districts. Non-financial enticements included housing and the introduction of peer review and recognition systems (Wilbulpolprasert and Pengpaibon: 2003: 1-12).

South Africa's approach has remained to build up a team of middle-class personnel, although that approach has attracted criticism (Perreira, Bugalho, Bergstrom, Vaz and Cotiro 1996: 508-512). Fairall, Zwarenstein, Bateman, Bachmann, Lombard and Majora (2005: 750-754) state that the scarcity of caregivers in South Africa is due to a deteriorating quantity of caregivers' actuality cultivated in the country. Suberdar (2005) argues that this is to a certain extent a result of the circumstance that training for caregivers, unlike that for doctors and other healthcare staff, is financed from the provincial health budget and therefore is restricted if there are other demands on the budget. There is a pressing necessity to broaden the teaching of caregivers, and make it a key national imperative.

South Africa's healthcare facilities depend on huge statistics of caregivers to provide these amenities. Augmented delivery proportion and the expansion in the number of persons living with Human Immunodeficiency Virus (HIV) contagion and Acquired Immune Deficiency Syndrome (HIV/AIDS) along with tuberculosis (TB) at hand, is a greater tension on the contemporaneous resources in the aforementioned country (Matsuvama 2007: 33). The excellence of preventive medicine is associated with the accessible assets, of which caregivers are an important constituent. Scarcities of caregivers are encountered in the state-owned preventive medicine facilities, rendering care to South Africans (Kahn 2008: 1).

Scholars have argued that the provision of excellent client compassion necessitates entire preventive medicine structure with proficient and enthused personnel, sufficient amenities and apparatus in addition to experienced and proficient management (South African Health Research Council (S.A.H.R.C) 2009: 46). The work atmosphere in most civic healthcare institutions in South Africa is challenging and packed with many demands such as the scarcity of personnel, deficiency of assets, deprived infrastructure, shortage of qualified specialised caregivers and debilitated administrative organisations (Dolamo 2005: 43; Dolamo 2009: 30; Geyer 2004: 34; Lephako, Bezuidenhout and Roos 2006: 29; Mzolo 2001: 38).

Inadequate workstations in healthcare organisations impacts on the capability of employees to achieve performance targets, quality healthcare outcomes. This hinders the process of attract, motivating and retaining staff. There are vital factors in the workplace that support the environment and positively contribute to patient outcomes and organisational cost-effectiveness. The aforementioned issues, as soon as prepared and maintained by suitable assets (mutually monetary and human), have a crucial impact in safeguarding excellence in preventive medicine, the institution and safeguarding an efficient wellness program proficient personnel and eventually the general worth of healthcare organisations (Department of Health 2013: 27).

The responsibility of administrators in a healthcare institution is to make sure that there is a positive operational environment and utilising all essential properties that empower personnel to deliver excellent care to clients (Germain and Cummings 2010: 433). According to Zurmely, Martin and Fitzpatrick (2009: 383), diminished self-confidence amongst nursing personnel plays a major role towards non-attendance, deficiency of enthusiasm, an augmented personnel turnover lowered moral and burnout. Burnout results in pessimistic outlooks that ultimately put the clients in jeopardy of receiving underprivileged client care and the learner nurses may take over and replicate those unconstructive outlooks and a low drive from their mentors in the practice environment. Given this predicament, it seemed crucial to develop guidelines to enhance the human caring attributes amongst the undergraduate nursing students in the teaching space and the experimental setting to promote the rendering of quality patient care.

Nursing in South Africa is facing a predicament. This is a concerning view articulated by the nursing profession across the country citing the increasing loss of knowledgeable nursing professionals from the unrestricted health sector as evidence also of the serious challenges the health system faces. These predicaments are also shared with the private health sector. Several surveys and research papers on the nursing profession have pointed to an array of the rationale for the disconcerting state of affairs in the nursing profession. This has been demonstrated in the reported decline of nursing care and in general the excellence of healthcare equally in public and private health care facilities (Department of Health 2008: 7). The SANC statistics make public that accusations against caregivers have amplified three hundred fold since 1996. In many circumstances, there is an indication of an unconstructive approach by the caregiver or clinician that ultimately leads to behaviour that result in misconduct. The aforementioned contraventions embrace straightforward contravention and other civil liberties infringement. According to SANC's stated proficient delinquency circumstances from 2003 to 2008, it is obvious that the privileges of clients and caregivers remained equally violated (Department of Health 2013: 25).

Deficiency of administration proficiency was acknowledged as a fundamental hindrance to healthcare provision in South Africa. Both the forfeiture of proficient caregivers utilising purposeful termination severance pay in the late 1990s and the relocation of caregivers and midwives and outside the healthcare amenities have reduced the proficiency at clinical and management level. Regardless of nursing administrators being fundamental to overcoming the struggle of delivery, there is inadequate investigations that examines which proficiencies are imperative for nursing administration and whether administrators have the expertise (Department of Health 2013: 26).

According to the Department of Health (2013: 24), unreliable substantiation supported by some investigations proposes that a value of nursing has dropped and the status of the profession has declined. A large number of caregivers continue to operate in a communal subdivision, which is faced with a deficiency of human resources, incompatible nurse-client proportions, scarcity of supplies, scarcity of treatment, workplace violence that influences excellence of provision distribution and nurturing morale. Media often describes health institutions as 'horrific' and 'dreadful', with health providers functioning in strained environments. Media news also report immoral behaviour, with caregiver-client associations characterised by reduced communication, and incidents of violent behaviour and ill-treatment. The nature of nursing is closely intertwined with the society it serves and as a result, the self-sacrificing, moral and caring nature of nursing needs to be re-established, taking into account the socio-political setting which impacts the nursing profession. The aforementioned requires powerful programmes that will highlight the professional ethos of the occupation n optimistically to the community and prospective nursing trainees (Department of Health 2013: 42).

2.7 CLINICAL LEARNING ENVIRONMENT (CLE)

Chan (2004: 666) describes CLE as a reciprocal web of powers in the clinical setting that influences the scholars' practical knowledge outcomes. The practical milieu is perceived as surroundings that permit learner nurses to

cultivate outlooks, proficiencies, interactive communication capabilities, decisive thought and clinical reasoning capabilities. In the experimental milieu, learners are capable of becoming skilled around the multifaceted healthcare matters of clients and practice carefully chosen procedural proficiencies (Swinny and Brady 2010: 60). Practice setting affords a factual milieu, which is necessary for acquaintance expansion, morals and capabilities. According to Salamonson, Bourgeois, Everett, Weaver, Peters and Jackson (2011: 262) nursing is a proficiency-based profession, necessitating learner nurses to acquire experimental abilities required in compassion. Facilitators perform a vital part during the knowledge acquisition progression for learner nurses in the clinical setting (Madhavanprabhakaran, Shukri, Hayudini and Narayanan 2013: 38).

SANC, the supervisory body of caregivers and midwives, as well as practical scholarship prospectus that accomplish the necessities of the Nursing Act, 33 of 2005. SANC (Regulation R425), stipulates that learner nurses registered for the aforementioned prospectus must be placed for 1000 hours annually in the practical setting to acquire experimental knowledge and accomplish their scholarship prospect (SANC 1985). The experimental scholarship is “a duration of conversion that allows novices to incorporate theoretical and applied expertise attained in the course of experimental assignment” (Chan 2002: 69). Learner nurses are required to attain specific proficiencies and the relevance of information, expertise, outlooks and principles during the clinical placement. Nursing is, in essence, a practice based profession, therefore clinical placement is vital and allows nursing students to combine cognitive, psychomotor and affective skills (Chan 2002: 517). Therefore, practical exposure is vital for efficient education and knowledge development.

Placement of learner nurses in the CLE is imperative and considered as an incomparable constituent of nursing learning (Bjork, Berntsen, Brynildsen and Hestetun 2014: 2958). Registered caregivers argue that chances are high that the aforementioned apply for employment in surroundings in which they encountered optimistic practice during pre-registration practical exposure. For

that reason, it is an essential undertaking to make certain of an efficient positive practice environment in all health facilities accredited for learner placement (Bjork *et al.* 2014: 2959). The following are the characteristics of an effective CLE:

2.7.1 Conducive environment

- Professional learning necessitates the practice milieu to be designed in such a way that it would be easy to incorporate theoretical learning that supports and develops students (McIntosh, Gidman and Mason-Whitehead 2011: 98). Scholars acquire knowledge efficiently in the setting that is motivating, accommodating and make them feel part of the multi-disciplinary team. An unorganised setting will make learner nurses feel defenceless, isolated and nervous (Emmanuel and Price-Miller 2013: 20).
- Clinical placement facilities are supposed to be co-operative and constructive to knowledge acquisition for learners to cultivate merits, competencies and capabilities essential for competent professionals (Billings and Halstead 2012: 311).

2.7.2 Communication of goals

- Learner nurses must be given adequate information and must be afforded a chance to raise questions related to experiential placement (Elcock and Sharples 2011: 70).
- Scholars require to be shown around the physical layout of the CLE and be assisted to master the structure of the environment (Hart and Holland 2010: 165).

2.7.3 Providing learning opportunities

- Proficiency in nursing skills is attained through experiential learning. This is attained by being involved in actual responsibilities in the clinical setting and by collaborating with experienced caregivers (Lechasseur, Lazure and Guilbert 2011: 1934).

- The CLE offers the real-life circumstance that is important for the expansion of the information, principles and competencies (Salamonson, Bourgeois, Everett, Weaver, Peters and Jackson 2011: 262).
- Instructors must ensure that placement facilities are conducive for scholarship and are ready for learner nurses beforehand, for them to be able to apply their theoretical learning into practice and enhance their proficiencies (Elcock and Sharples 2011: 33).

2.7.4 Providing evaluation and feedback

- The facilitators in the clinical setting should be approachable to scholars' and be ready and willing to provide help for them to meet their requirements in any way possible. They should also take note of individual learner's peculiarities and give comments where necessary. This act generates compassion at a setting for knowledge acquisition (Darcy Associates 2009: 16). Simulation benefits students by enhancing active learning, a safe learning environment, assessment, immediate feedback to the students, increased confidence, learning at their own pace, and unlimited repetition of learning opportunities (Bruce, Kloppe and Mellish 2011: 243).

2.7.5 Self-directed learning

- Undergraduate learner nurses in clinical settings developed objectivity utilising self-reliant scholarship when given the opportunity (Bjork, Berntsen, Brynildsen and Hestetun 2014: 2959).
- Facilitators believe that undergraduates must take more accountability for their scholarship so that they can identify learning opportunities (Emmanuel and Price-Miller 2013: 20).

2.8 THE ROLE OF THE CLINICAL STAFF IN THE LEARNING PROCESS

Jackson and Mannix (2001) averred that learner nurses assumed the responsibility of personnel in the placement facilities during their education and development. There is a lack of documentation that records the involvement of clinical staff in assisting pre-graduate nurses learn about caring. Instructors play an important role in the training and growth of the learners' careers. Qualified nurses that assume tutor responsibility ought to possess special capabilities to advance learner nurses to be proficient (Sabog, Caranto and David 2015: 5). Creating an effective and conducive, CLE requires that Clinical Facilitators (CF's) have particular attributes and qualities (Bruce *et al.* 2011: 109; Sabog *et al.* 2015: 10). The following are the key abilities that CF's should have for them to do their work effectively:

2.8.1 Approachability

- Nurse educators are required to be considerate and caring. The aforementioned has a pronounced bearing on learners' performance in the experimental setting (Sabog *et al.* 2015: 15).
- Clinical facilitators must be compassionate and relate freely with learners, they ought to be sociable, accessible, inspire reciprocal admiration and considerately pay attention to learner nurses (Bruce *et al.* 2011: 109).

2.8.2 Welcoming

- Orientation is one of the best ways to ensure that students feel welcomed in the clinical placement area. Undergraduates are provided with all information they need (Elcock and Sharples 2011: 70).
- Nurse educators should ensure that the CLE is a favourable setting for knowledge acquisition and is organised for learner nurses before their arrival so that they can apply theoretical learning into practice and advance their expertise (Elcock and Sharples 2011: 33).

2.8.3 Supportive

- Aside academic pursuits, learner nurses jostle with physical, emotional, financial and even family issues that have the potential to negatively impact on their academic pursuits (McIntosh, Gidman and Mason-Whitehead 2011: 192). Nurse facilitators must be dedicated and proficient to backing learners.
- Clinical supervision allows students to receive formal professional support by experienced and skilled clinical supervisors (Gopee and Galloway 2011: 151).
- Students require personal mentors (tutors) from the NEI who can support and advise them on personal and course-related problems (Hart 2010: 34, 36).

2.8.4 Obtainable

- Students need to have a personal nurse facilitator from the nursing school, which is accessible to the learner during their course of study (Walsh 2012: 199).
- To accomplish interventions appropriately, the nurse educators' supervision is imperative (Sabog *et al.* 2015: 16).

2.8.5 Knowledgeable

- Nurse educators must be conversant and proficient with nursing procedures and understand that information; knowledge and proficiency are significant and indispensable constituents for efficient nursing education (Sabog *et al* 2015: 15).
- Clinical facilitators play -an important role in the individual, proficient and theoretical advancement of learner nurses. The aforementioned must have expertise and qualities essential to enable learners' knowledge acquisition (Bruce *et al* 2011: 107).
- Responsibilities of instructor comprise establishing and synchronising learners' education accomplishments in the CLE; evaluating performance, comprising proficiencies, outlooks and conduct;

networking with role players; overseeing scholars' scholarship and offering a productive feedback, and observing accomplishment of learning goals (Elcock and Sharples 2011: 23).

Gumabay (2017: 84) mentioned that clinical experiential learning is an important and essential characteristic of nursing instruction. All the models and theories learned in class may be accomplished while operating in the CLE. Learners improve abilities, progress appropriately and advance their capabilities as they spend long hours interacting with healthcare users, facilitators and multi-disciplinary staff in the CLE. Furthermore, clinical exposure improves the critical thinking abilities of learner nurses. Considering the individual experiences of the researcher, going to clinical practice elicits varied responses and reactions from nursing students. Most are happy and composed, however, some learners are nervous and stressed. Moreover, the NEI has the responsibility to be influential in backing learner nurses' engagements and responses for the eight-hour obligation and to assist scholars to practice the aforementioned incidences utilizing before and after consultations (Gumabay 2017: 84).

The objective of educating learner caregivers is to make certain that learners will be capable to deliver excellence nursing to look after clients (de Swardt, 2013: 1). Caregivers have to deliver excellent client maintenance in a conducive operational atmosphere which is appealing and inspiring, wherein caregivers need to remain, develop, and contribute information and knowledge, expertise and capabilities (Hughes 2008.n.p.). Breier, Wildschut and Mqgqolozana (2009: 1) argue that the nursing profession in South Africa nowadays requires care. These investigators based their argument on the fact that thousands of caregivers have left the country in pursuit of better working settings out of the country. Those caregivers, who remain, face progressively challenging amount of work as HIV/AIDS and TB places a huge demand on those in the nursing environment. While there are numerous applications for caregiver training courses that outnumber the available places, the nursing profession is not growing in proportion. Nursing attrition rate is high, both

during and after training. Two of three of the working caregivers are above 40 years of age. The appearance and social standing of nursing are deteriorating. Formerly viewed as an honoured career for females, nowadays is over-shadowed by other high paying careers. However, nursing is the moral fibre of preventive medicine in South Africa and it desires to be cultivated if the country is to overcome the trials facing the sector (Breier, Wildschut and Mgqolozana 2009: 1).

According to Edgecombe, Monahan, Meyer, LePage and Erlam (2013: 5), as science, technology and education have advanced; simulation has become a refined and inventive education and training method replacing the old-fashion educator-centred methodology like lecture, discussions and skills demonstrations. This approach of education and knowledge generating is highly collaborating, permitting numerous learning outcomes in an accurately simulated atmosphere, whilst reflecting the clinical practice setting. However, according to the investigator's experience as an instructor and educator, the limitations regarding the use of an innovative learner-centred approach are not only the large numbers of learner nurses, limited resources (both human and material) and time constraints. The researcher also believes that these innovative teaching strategies methods are more effective when the level of motivation (both the intrinsic and extrinsic) amongst the learner nurses is very high.

According to Li, Tsai, Tao and Lorentz (2014: 246), in the blended learning setting, learners take profit from the outdated direct scholarship atmosphere where they interact with their facilitators, as well as enjoy the flexibility that e-learning offers. It was confirmed that association amongst the healthcare user and the carer is needed for a compassionate affiliation understanding the learner nurse (Paterson 1991) necessitates that nurse educator has an adequate connection with the learner for the aforementioned to happen. If compassion is considered essential and the archaeology of nursing training, facilitator's assessment must reproduce these score instruments in which quantity low implication education performances must be grounded on

principles that incorporate compassion unambiguously to education as a caregiver. It is questionable that evaluation apparatuses based on the quantitative paradigm are capable of capturing the process of caring in nursing education. Valuation instruments that make use of comprehensive, cross-discipline standards are not suitable, for the reason that facilitators demonstrate consideration for learners using their former experience as caregivers. The process of teacher assessment in nursing education must be restructured to emphasise the caring and responsiveness that is integral in the nursing occupation.

According to Gumabay (2017: 91), a surrounding exploration on the matters and experiments, proficient by learner nurses on their understandings with the NEI need to be discovered using mixed-method strategies by the investigators. Additional exploration scholarships, mixed-method tactics, must be piloted for continuous information development and improvement of the learner-facilitator proficient association not only focusing on learning-related matters but also in actual school setting. The participating nurse education institution must constantly perform personality development training and seminars, to constantly shape the development and improvement of the NEI. There ought to be continuous and consistent consultation of the NEI with all other nursing education stakeholders to deliberate on experimental learning matters not only on proficient and administrative duties but also, on the character of the NEI touching the atmosphere of the associated scholarship practice of the learner nurses.

The investigation conducted by Jameson, Habner and Wilson (2006: 3) established prospective worth for pre-graduate learner nurses tasked to experimental variations that encompassed weekends, however, elevated matters that ought to be well-thought-out in requiring learners to undertake these allocations. The relaxed environment on the weekends provided greater time and access to resources for learning than exists on weekdays. There were also more opportunities for students to feel included in the team, promoting teamwork. The aforementioned study happened in a setting

wherein, relatives accomplish a vital responsibility in consumer service necessitating learners to acquire expertise in functioning with clients and significant others. Learners articulated their capability to advance time managing abilities through learning occasions to undertake and efficaciously accomplish complete client capacity as well as adopt larger accountability. The aforementioned has the possibility, to equip them well for future responsibilities as qualified registered nurses.

Paterson's (1991) investigation of practical education recognised illustrations wherein nurse facilitators alleged that they were transferring compassionate performances to learner nurses however; learners did not receive the intended communication. Paterson witnessed numerous instances in which the clinical instructors cared for a client in compassionate method whilst the learner nurse left the clients' apartment to finalise uncompleted duty (Grigsby and Megel 1992). Paterson (1991) recognised the subsequent pointers of consideration by NEI in her study of experimental education of being acquainted with the learner as a human being, listening to the learner, upholding privacy concerning secretive information disclosed by a learner, performing as the learner's supporter, inculcating in learners the visualisation of optimism and accomplishment, being non-discriminatory, being proficient as a nurse educator and a practitioner, and being cultivating.

According to Thopola and Lekhuleni (2016: 981), lack of supervision, performance of non-midwifery duties, being workforce rather than participating in learning activities were perceived by students as factors influencing their learning in the clinical settings (Letswalo and Peu 2015: 7). Mampunge and Seekoe (2014: 1934) and Bam, Oppong and Ibitoye (2014: 54), found that there was an incongruity between theoretical instruction and the clinical procedures. The article further positions that absence of communication amongst facilitators and the registered caregivers, as they were not given the students' learning outcomes to enable them to impart and guide the students. The scarcity of material resources and supplies had an adverse consequence on the learning experience of nurse learners.

Gumabay (2017: 91) contends that learner nurses have shared opinions on the considerate deeds of the NEI: considerate deeds are real in improving association amongst learner nurses and their NEI. The aforementioned investigator concludes that NEI affiliates possess not only professional characteristics, but also, personal qualities that are innate and at the same time expected of a mentor.al, as soon as offered appropriate induction, consideration, and facts by the NEI, the learner nurses are trained to develop self-confidence, confidence in execution all-inclusively, interactively, and being sensitive to cultural differences while on related learning practice. This investigator further concludes that excellence linked education practice of learner nurses with the assistance of NEI equip learners for their forthcoming careers as qualified caregivers (Gumabay 2017: 91).

To maximise learners' clinical learning exposure, it is essential to enhance the human caring attributes amongst the undergraduate learner nurses. The objective of teaching nursing students is to make certain that learners have the capability to offer excellent nursing care to clients (de Swardt 2013: 1). However, despite the trials, there is still several South African caregivers who reveal high levels of human caring attributes towards their clients and have an inner drive to continue offering quality patient care with inadequate human resources. According to Fongqo (2009: 58); Selebe and Minaar (2007: 53); National Department of Health (2008: 7) and Vhuromu and Davhana-Maselesele (2009: 66-67) caregivers based in rural parts of South Africa also deliver quality client care in PPE. An atmosphere of that nature prevails mostly in public healthcare facilities. However, the extensive literature search specified that there is restricted confirmation that broad exploration was performed in contemporary ages to discover how caregivers retained high levels of human caring attributes and provide quality patient care in South African context especially in KZN province, and continued to be good role models to novice nurses and student nurses despite the challenges they face.

2.9 EDUCATIONAL PRACTICES

Expert nursing practice necessitates thoughtful expertise for clinical judgement and decision making; hence, the expansion of intellectual expertise is crucial in undergraduate nursing education, since it makes learners to utilise thinking and problem-solving skills to analyse situations and make decisions relevant to patient care (Marchigiano, Eduljee and Harvey 2011: 144). Facilitators must concentrate on content that will meet the difficulties new graduate come across, the innovative methods of knowledge acquisition and innovative methods of enthusiastically involving learners. Lecturers are inspired to diverge from content driven prospectuses and incorporate inventive learner centred education approaches as no singular education approach will address the education desires of every single scholar (Murphy, Hartigan, Walshe, Flynn and O'Brien 2011: e142). Teaching and learning approaches must also be linked with teaching and learning ideologies associated with adult education (Applin, Williams, Day, and Buro 2011: 129). This section will address the challenges experienced by facilitators and the different teaching and learning strategies. This section will address difficulties encountered by nurse educationalists and the diverse education and erudition approaches.

2.9.1 Difficulties encountered by nurse educationalists

The trials facilitators come across in using coaching and education approaches that enhance human caring and comprehensive clinical judgement are defined briefly. Horstfall, Cleary and Hunt (2012: 930), state the restricted enthusiasm, obligation and will power of instructors to reflect critically on the educational practices utilised is common and challenging. Botma, Brysiewicz, Chipps, Mthembu and Phillips (2014: 16) affirm, a complete paradigm shift of the nurse educators' outlook is not only a concern regarding the facilitators' teaching approach or tactic but includes the reflection on ones' own pedagogy that provides the foundation for effective teaching process and authentic educator confidence (Horstfall *et al.* 2012: 93). According to Palese, Sarani, Brugnolli and Regattin (2008: 1285), scanty

is well-known about the difficulty of instruction approaches because, they are made up of numerous constituents. The aforementioned investigators cited illustrations such as the instructors' enquiring capabilities, the worth of the setting, the influence of the milieu, the proficiency of the educationalist and the influence of the NEI's or subdivision's philosophy of education. Furthermore, coaching approaches cannot be homogeneous but be determined by various issues which are challenging to control and further hinders the utilisation of coaching and scholarship approaches that enhance human caring and sound clinical judgement.

The importance on teaching additional subject matter in the lecture hall as a replacement for concentrating on relating learnt information in practice is alleged by both Del Beuno (2005: 281) and Allen (2013: 13) as a challenging concern linked with lecture-based scholarship. Whilst Benner, Sutphen, Leonard and Day (2010: 14) believes for instructors to abstain from utilising only lecture-based erudition; the aforementioned authors inspired professors to involve learners in clinic-like education involvements in which it is expected of learner nurses to acquire skills of applying theoretical knowledge into practice, to contemplate about altering circumstances for the good of the client. Audétat, Dory, Nendaz, Vanpee, Pestiaux, Perron and Charlin (2012: 216) argue human caring and clinical judgement is the keystone of therapeutic proficiency however, instructors discover it challenging to deal with their twofold responsibility of being caregivers as well as instructors. The aforementioned researchers' findings revealed that the facilitators came across the following barriers: how to accomplish clinical judgement complications, failure to record good performance and the absence of remediation options (Audétat *et al.* 2012: 217). Lack and Bruce (2014: 157) affirmed that numerous learner nurses are from formerly underprivileged upbringings. These scholars' cultural circumstances have had a negative impact on their exposure to scientific terminology and their general reading and writing skills are poorly developed; therefore, these students require a great deal of academic support (Lack and Bruce 2014: 157).

2.9.2 Teaching and learning strategies

Nurse educators need stay up-to-date with the changing clinical milieu and must consequently acclimatise their training and erudition methodologies in both the theoretical and the clinical surroundings by employing inventive instruction approaches (Allen 2013: 3). Human caring and clinical reasoning are essential to nursing profession, however, facilitators found it challenging to explain and for learner nurses to acquire due to compound, tacit and obscure nature of these concepts (Delany and Golding 2014: 1). According to Brandon and All (2010: 89) and Stanley and Dougherty (2010: 380), numerous instructors carry on to impart knowledge in the similar technique they were educated. They carry on to re-organise the similar content-laden material, which they convey to learners by means of the old-fashioned lecture-based techniques. The utmost communal coaching approach utilised in adult instruction programmes is a lecture and it is broadly used to provide the theoretic constituent of nursing education. Though the lecture technique as operational as other approaches in coaching information, it is unsuccessful to inspire critical thinking (Clynes 2009: 22). Benner *et al.* (2010: 65) exposed that educationalists depend on computerised presentation software and the usage of lecture-based approaches; experiential learning was mostly absent. The situation does not favour the development of students' clinical inquiry skills and their ability to use knowledge in specific clinical situations (Benner *et al.* 2010: 65). Despite limited evidence and the difficulty in teaching and learning approaches can be utilised by nurse educators to promote the development of human caring attributes as discussed in the section below:

2.9.2.1 Think aloud approach

The think-aloud approach is technique of describing intellectual progression by means of expression (Forsberg, Ziegert, Hult and Fors 2014: 539). Process-oriented education and scholarship methodologies give emphasis to the significance by means of intellectual techniques of tutoring such as thought processing and intellectual growth to instruct learners for ability rather than competency, both of these are essential to the progression of clinical

judgement (Banning 2008b: 10). Delany and Golding (2014: 2) describe a similar approach as creating intellectual visible. It involves identifying and repacking the thinking steps used by experts when they engage in clinical reasoning into thinking routines. The following pedagogical philosophies support this tactic:

- Decreasing multifaceted professional philosophy to a philosophy routine that a learner knows how to use, in a system of popularisation of information to decrease the recognition work of human caring and clinical judgement.
- Learners can be effectually assisted to study by partaking in the day-to-day undertakings of experts in their field, which is thus also a form of proficient socialisation.
- Delany and Golding (2014: 2) argues that when instructors think about own intelligent, they are engaging in contemplative and meta-cognitive thinking and this help them to cultivate an understanding of their own clinical judgement prior to educating others.

Forsberg *et al.* (2014: 538) collected data by means of the think-aloud approach in their descriptive qualitative research exploring how knowledgeable paediatric nurses' intellectual capability. The aforementioned authors stated the think-aloud approach appeared to work as an operational technique to gain entrance to the nurses' cognitive progression used in clinical rational.

2.9.2.2 Case based learning

Case based learning is an andragogic approach that scrutinises contextualised questions based on real life problems or cases. The usage of case studies in the schoolroom offers realistic difficulties to stimulate critical thinking and enhance the development of human caring attributes (Flood and Robinia 2014: 329). Making use of standardised case studies in the classroom exposes all learners to a specific, interesting case allowing them to systematically developed competency in clinical reasoning (Postma and White: 2015: 75). The case study is like a snapshot of a scenario during a

specific period in time where you are asked to evaluate that snapshot and answer certain questions. To summarise a case study is a tool that can be utilised by nurse educators to engage students in reflective discussions thereby encouraging higher order thinking and problem-solving (Malesela 2009: 2). Instructors can make use of real life cases or scenarios and teach learners to analyse the care receivers' situations by following the eight steps proposed in the clinical reasoning cycle of Levett-Jones, Hoffman, Dempsey, Jeong, Noble, Norton, Roche and Hickey (2010a: 517), summarised below:

Step1 (look) is situated at the top of the circle and presented as Consider the patient in the Colour Red. Clockwise Step 2(Collect): referred to as Collect cues/ information in orange colour, and followed by Step 3 (Process) noted as Process information in yellow. This is followed by Step 4(Decide) as Identify patient problems/ issues in green. In the middle at the bottom of the Circle, Step 5 (Plan) in turquoise is to Establish goal/s. Moving up on the left hand side the light blue colour refers to Step 6 (Act) meaning Take action followed by Step 7(Evaluate) or Evaluate outcomes in dark blue above it. Finally, Step 8 (Reflect) is indicated in purple and represents Reflect on process and new learning.

Malesela (2009:1) conducted an investigation that discovered that using a case based learning as a teaching approach amplified critical thinking, theory-practice incorporation and progression in presentation expertise. Having learners work through a scenario or case study permits them to apply theoretic conceptions to practice setting (Flood and Robinia: 329). Case studies must be carefully chosen bearing in mind the intellectual capacity of the learners and must be structured in the similar sequential classification as the proceedings had originally unfolded in reality. The educationalist who decide on the case must be cognizant of the teaching objective and must amend the case study to attain that particular objective (Kassirer 2010: 1121). Good case studies are constructed to be realistic, appropriate, thought-provoking, engaging, informative and when working with inexperienced undergraduates, teaching and learning must begin with simpler cases (Posta

and White 2015: 75). Case based learning inspire learners to work through problematic circumstances. It provides a chance to deliberate on real life circumstances in a safe milieu and inspires one's capability to reason critically since, clients offer no concrete responses (Lin, Han, Pan and Chen: 2015: 150). The aforementioned researchers conducted a research displaying that utilising real life case studies is an efficient approach to link the gap amongst learning in the theoretical and clinical milieu. According to Potgieter (2012: 6), using case-based learning is one technique of executing constructivism in nursing education. As learners work through case studies, they attain an understanding of the difficulties caring for diverse clients and reveal a growth in understanding, nursing procedures and self-confidence. Yoo and Park (2015: 166) confirmed that case-based learning is a collaborative learner-centred teaching and learning approach that draws on real life situations to promote authentic learning.

2.9.2.3 Reflective self-regulated learning

The self-regulatory learning strategies are those that learners use to monitor, control and regulate cognition or thinking as well as to promote academic behaviour. Assisting learners grow metacognitive or reflective thinking nurtures the confidence desired for the quick making of pronouncements. The three types of self-regulation support the development and acquisition of higher order thinking skills such as interpretation, analysis, inference, explanation and evaluation (Kuiper, Pesut and Kautz: 2009: 77-78). A brief discussion of each of the three types of self-regulated learning follow hereunder:

- Behavioural self-regulation or self-monitoring includes the sub-process of self-observation, self-reaction and self-judgement. Self-monitoring refers to paying deliberate attention to the behaviour used to attain goals and motivates improvement in learning.
- Metacognition self-regulation or self-evaluation includes the sub-processes of goal setting, self-efficacy, knowledge use and thinking strategies. Self-evaluation is a key component of reflection, which

influences critical thinking and the development of clinical reasoning skills.

- Environmental self-regulation of skills, activities, physical context and the relationship with the preceptors, staff and patients is necessary to determine the context of clinical reasoning.

2.9.2.4 Reflection / Reflective thinking

Reflective thinking is an active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that supports it and the further conclusion to which it tends (Dewey in Zha, Adams, and Mathews-Ailsworth 2012: 2551). Within the context of reflective learning individuals, reflective thinkers and non-reflective thinkers (Josephsen 2014: 803 and McDonald, Straker, Schlumpf, and Plack 2014: 3). Critically reflective practitioners critically evaluate experiences and situations are self-aware, frame problems within their contexts in which they find themselves. They use multi-dimensional perspectives in working with problems and use reflection-for-practice, reflection-in-practice and reflection-on-practice. They tend to use resources, their prior knowledge and literature in order to arrive at the alternative views and possibilities and are not scared to try out different methods. They tend to reject being controlled by common practices and they never take things for granted. They are change agents, self-powered and willing to empower others to discover and use their unique skills through emancipatory process. Their critical reflective competencies are based on the empirical-analytical, historic-hermeneutic and critical/ self-reflective knowledge (Maree and van Rensburg 2013: 45-49 and Thompson and Pascal 2012: 322).

Reflective practitioners concentrate on the why and not how they authenticate the assumptions so that they can change their perspectives and have specialised knowledge and skills in their field of interest. They critically think, make good decisions, are self-directed and tend to be lifelong learners. They are unable to articulate what happens in practice, are not defensive about

their own practice, accept that knowledge can emerge from within or outside clinical practice, acknowledge the significance of reflection, successfully engage others in meaningful discussions about practice and they support and promote team and peer learning. They respond positively to changing situations and do not rely on the use of technical rational knowledge alone. They successfully use the empirical-analytical and historic-hermeneutic knowledge only (Posthuma 2012: 1-9 and Walker and Lovat 2015: 125). However, non-reflective practitioners are very descriptive without exploring their experiences. They will not check validity of their information in order to make informed assumptions, thus making their assumptions invalid and their opinions unsupported and they do not consider contextual factors when viewing computer situations. They mostly use concrete thinking rather than abstract thinking and explain their experiences impersonally. They tend to be descriptive in their thinking and they are routinized practitioners. They are highly dependent on the empirical-analytical knowledge (McDonald *et al.* 2014:3 and Walker and Lovat 2015: 125).

2.9.2.5 Problem solving/ Problem based learning

According to Morin, Thomas and Saadè (2015: 340) and Yoon, Woo, Treagust and Chandrasegaran 2015: 218) problem solving is the process of generating alternatives and solutions to complex problems using research skills, creativity and critical thinking. Effective problem-solvers are optimistic, they believe in a careful, persistent analysis of a problem. They are concerned with accuracy and if necessary, they check and recheck each step of the problem to be solved. They read and reread instructions to avoid guessing, they break the problem into manageable parts, are most likely to use different problem-solving methods and make mind maps and diagrams for themselves. They constantly ask themselves questions, talk to themselves in order to clarify their thoughts for effective problem-solving and also convert abstract problems into concrete ones by recreating them for themselves (Whimbey, Lochhead and Narode 2013: 25).

In contrast, poor problem-solvers often convince themselves that either they know the answer to the problem or they do not and they are stuck in this thinking process. If they do not know the solution to the problem, they tend to give up easily. They lack confidence and experience in solving problems effectively and do not engage in the process of gradual analysis during their problem solving. They tend to be sloppy and inaccurate at the very critical phases of the problem solving. They tend to be sloppy and inaccurate at the very critical phases of the problem-solving process. They do not seek clarity of the problem to be solved and do not break down the problem into manageable parts. They are likely to follow their intuition, jump to conclusions and they tend to guess their way out of a problem. They work rashly, lack perseverance to engage in a slow, systematic approach to problem solving and are careless in their reasoning (Whimbey *et al.* 2013: 25).

2.9.2.6 Rational decision-making

Decision-making is a complex process that involves choosing an appropriate action from one or more possible alternative actions in order to make an astute judgement. It requires the utilisation of knowledge and experience that is incorporated with heuristic, thus, enabling the practitioner to engage in effective decision-making (Johansen and O'Brien 2015: 47 and Kilpatrick 2012: 169). Good decision-makers are highly adaptable to the task content and contextual patterns, use their large knowledge-based effectively and engage in pattern recognition in relation to the task. They are highly motivated to learn.

2.9.2.7 Clinical post-conferences

Clinical post-conferences are designated time for students to share knowledge gained through clinical experiences with fellow students and nurse educators. Post-conference is a time when students actively reflect and apply problem-solving techniques to synthesise clinical learning. The intentions of these conferences are to facilitate learning and stimulate students' critical thinking skills while applying theory into practice (Megel, Nelson, Black, Vogel

and Uphoff: 2013: 525). Post-conferences provide opportunities for students and educators to discuss clinical experiences and case studies, share information, analyse problems, clarify relationships, vent feelings and identify further problems (Potgieter 2012: 5). Clinical post- conferences typically focus on students' analysis of their clinical experiences. Nurse educators must utilise these post-clinical conferences to ask students stimulating questions to facilitate critical thinking thereby encouraging students to reason clinically (Megel *et al.* 2013: 525). They conducted a study on the perceptions of students and educators regarding clinical post-conferences and found both groups consider this learning environment as important and it ought to be enriched by the educators (Megel *et al.* 2013: 525). Hence, an inquiring mind, critical thinking and problem-solving skills are developed (Potgieter 2012: 6).

2.9.2.8 Virtual learning environment

Flood and Robinia (2014: 329) state video clips and photographs can be useful for portraying applications of theoretical concepts. The aforementioned authors illustrate this by providing the following example:

During a class on post-operative care, showing a short video on patient controlled analgesic devices can provide a link between conceptual knowledge, clinical skills and bedside technology. The importance of reflective activities such as using short video clips from websites. Conferences can be helpful in engaging students to contemplate holistic nursing interventions. Electronic medical records can be used to highlight practice relevant to a specific topic, for example, documenting assessment data, analysing vital sign trends or reviewing prescribed medication orders (Flood and Robinia 2014: 329). Forsberg *et al.* (2014: 539) describe virtual patients as interactive screen-based computer simulations of real life clinical scenarios for the purpose of healthcare and medical training, educate or assessment. Virtual clients simulate the encounter between a healthcare professional and a client. Instructors can use this teaching and learning approach for determining the learners' learning capability as well as the assessment of the learners. The

above mentioned researchers conducted a descriptive qualitative research with the aim of exploring experienced paediatric care givers reason regarding virtual client cases and how they make clinical decisions. They discovered virtual clients seem to be a possible model for assessing the clinical reasoning process as well as for making clinical decisions.

2.9.2.9 Concept based learning

Content overload has led to facilitators backing concept-based learning that will help students to gain a deep understanding of major nursing conceptions (Allen 2013: 1). According to Charlin, Lubarsky, Millette, Crevier, Audétat, Charbonneau, Fon, Hoff and Bourdy 2012: 455), concept maps are graphic tools for organising and representing knowledge. Chabeli (2010: 1), identified concept as a stimulating learning strategy to facilitate critical thinking by encouraging learners too connect new knowledge to their prior learning, and to give learners an opportunity to gain further, wider and more varied knowledge to their prior learning, and to give learners an opportunity to gain further, wider and more varied knowledge of a number of concepts in a short period of time. The implementation of concept mapping includes assimilating new concepts in circles or boxes, creating hierarchical arrangements between concepts and sub-concepts, and identifying relationships between concepts and sub-concepts which can be connected with lines or linking words (Charlin *et al.* 2012: 455). Concept mapping is an approach for learners to develop clinical reasoning skills (Rochmawati and Wiechula 2010: 245). The shift from concept-laden curriculum to teaching key concept permits learners to focus on need-to-know or essential content that will be applicable to nursing (Stanley and Dougherty 2010: 380).

2.9.2.10 Questioning

DeBourgh (2008: 77) emphasises the use of classroom response systems and high-level questioning to enhance learners' participation and feedback even in larger size classes. Using questioning, facilitators can provide classroom environments that encourage reasoning instead of recall

(DeBourgh 2008: 77; Russel, McWilliams, Chasen and Farley 2011: 13). New technology known as I-clickers or audience polling systems and interactive boards are growing in popularity. Although very expensive, they provide nurse educators with a valuable teaching and that increasing student interaction and provides immediate student feedback (DeBourgh 2008: 77 and Russel *et al.* 2011:13). Classroom technology such as I-clickers is a tool that facilitators may utilise to engage scholars in meaningful learning and has the potential to improve practice. Educators can select or create questions to promote synthesis and the application of complex concepts that assist learners to develop advanced reasoning skills (Flood and Robinia 2014: 329). In the absence of interactive boards and I-clickers instructors can utilise questioning throughout their teaching session just as effectively. Asking simple questions that require reflective thinking is one way to promote human caring attributes and quality nursing care (Lim 2011: 53). The instructor must pose questions that assist learners to associate ideas and feelings about things that occur, to integrate aspects, ask questions to validate knowledge generated from the practical experiences and make the learners aware of what they have learned (Palese, Saiani, Brugnolli and Regattini 2008: 1286). Using questioning enables instructors to clarify misconceptions immediately thereby enhancing comprehension (Flood and Robinia 2014: 329).

2.9.2.11 Outcome-Present State-Test Model

The outcome-present State-test model (OPT) of clinical reasoning provides a framework for coaching clinical expertise to learner nurses. The OPT model is a structure or blueprint that assist learners organise the thinking involved in clinical judgement (Kuiper *et al.* 2009: 3 and Harmon and Thompson 2015: 64). The OPT model of clinical judgement provides a structure for linking nursing diagnoses, interventions and outcomes and promotes the organisation of client needs and nursing care around key issue (Bland, Rossen, Bartlett, Kautz Carnevale and Benfield 2009: 64). In utilising the OPT model, the client needs and nursing care around key issues (Bland *et al.* 2009: 1 and Harmon and Thompson 2015: 644). In utilising the OPT model,

the client scenario/ story serves as the foundation for a complex uncertain problem and is the stimulus for the clinical reasoning task. Once the essential elements of the clients' scenario / story are written by the learners on the OPT model worksheet, the next step in the reasoning process is to map out and visually represent the relationship between medical and nursing diagnoses using reasoning web which is a teaching learning tool similar to concept mapping. As learners think reason and explain the relationships between nursing problems and nursing care needs, they draw a map by sketching lines of association. As they draw these lines, they must verbalise and explain why the diagnoses are related or not to one another. The reasoning process used to understand the cues from the clients' story and the relationships that emerge, reveals a focus problem. The nursing diagnosis with the most connections emerges as the priority problem. The thinking involved in making clinical judgements involves metacognitive awareness critical, creative, systems and reflective thinking (Kuiper *et al.* 2009: 4).

2.10 THE SUMMARY OF THE CHAPTER

This chapter covered the literature search, whose foundations were related to the four key conceptions namely: adult learning, concepts caring, clinical learning environment and educational practices. The chapter involved the documentation of the information gap in the existing body of knowledge. The next chapter explains the theoretical underpinning of the study, the ten factors relating to the caring philosophy by Jean Watson, adult learning theories, and the four main concepts: nursing, environment, person and health.

CHAPTER 3: THEORETICAL FRAMEWORK

3.1 INTRODUCTION

The previous chapter articulated the debate relating to adult learning and andragogy, as well as an in-depth description of the concept of caring. The chapter also undertook an exploration of the clinical learning environment, an investigation of educational practices that may influence the development of caring attributes amongst nursing students and newly graduated professional nurses and an exploration of nursing curriculum and various teaching and learning strategies. The caring theories that were described by diverse writers offered a framework within which human caring attributes can be enhanced in the nursing education sector. In recognising the necessity to clarify the concept “caring” in the nursing career, numerous prototypes such as positive practice environment, the formation of therapeutic milieu were proposed as prototypes to advance compassion within the caregiver-client association. The information gathered formed a foundation for the investigator to advance a theoretical structure.

3.2 A CONCEPTUAL FRAMEWORK FOR THE CURRENT STUDY

A theoretical structure formed the foundation and support for the entire thesis from which it was possible to construct the rationale, the problem statement, the purpose, the significance investigation problems and literature appraisal, investigation methodology and analysis and the conclusion for the study (Simon and Goes 2011; Grant and Osanloo 2014). Contrary to this, Kelly (2010: 285) suggest that theory is introduced when one begins to identify the research questions. Trafford and Leshem (2008) describe a theoretical structure as the academics’ plan, which is extra modern and outlines the terrains to be explored, an instrument for methodical theoretical engagements. The mixed-method strategy, a theoretical structure can be utilised as a theoretic lens to direct the investigation. The model outlines the

category of inquiries that the researcher will probe with the respondents (Creswell and Creswell 2018: 72).

Creswell and Creswell (2018: 72), argue that philosophical usage in mixed approaches research may comprise utilising model deductively, in quantitative assumption challenging and validity, or in utilising it inductively as in an escalating qualitative philosophy or design. To go on board on this, the investigator deliberated and elucidated how the theoretical framework for the investigation was nominated in the subsequent subdivision. In the present investigation, the quantitative data was composed utilising the Caring Behaviour Inventory (CBI-42) researcher received permission from the authors (Wolf, Giardino, Osborne and Ambrose 1994) questionnaire. Chapter Two discovered the gap in the existing literature, aided the investigator to distinguish amongst what must be included or omitted from this scholarship. Chapter 4 focuses on selecting the methodology of the research; the choice was guided by the conceptual paradigm adopted from this chapter.

3.3 SELECTION OF THE CONCEPTUAL FRAMEWORK FOR THE STUDY

The selection of a framework was based on the problem, the purpose, the significance research questions of the study in order for the theoretical framework to guide the option of the research design and data analysis (Grant and Osanloo 2014: 17).

3.4 OVERVIEW OF THE THEORY

Watson (1988: 11-15) argues that three factors characterise Watson's Caring theory: This theory puts prominence on the significance of the lived experiences not only of the one cared for but also of the caregiver. They mutually come cooperatively in a caring instant that becomes part of their mutual lived experience. The theory recognises the exclusive magnitude of brainpower body-spirit without cooperation the completeness of the human being (Watson 1988: 11-15). Watson's theory (1988: 175-181), of nursing

ethics and overtly recognises numerous traditions of knowing, including pragmatic, artistic, decent, and individual knowledge.

Watson's theory for human caring (1979, 1985, and 2008) gives the underpinning to scrutinise the relations of caregiver caring behaviours and client contentment. Watson (1985: 11), argues that caring is grounded in the "humanistic-altruistic worth arrangement" that principled viewpoint the variety and the exceptionality of others. A human being's belief system and ethical principles affect how caring performances are expressed (Watson 1985: 11). The main fundamentals of Watson's theory are (a) the lengthy opinions of a nursing career, health, environment and the person/human, (b) the curative issues, (c) the transpersonal caring associations, (d) the caring occurrence/caring moment and (e) caring therapeutic modalities. The four chief perceptions of the nursing profession as explained in Watson's theory are presented hereunder:

3.5 FOUR MAJOR CONCEPTS OF THE THEORY

Nursing practice and theory are based on the four concepts: a) human being/person, b) health, c) environment and d) nursing. The incorporation of the four main concepts allows the establishment of the curative milieu for both the caregiver and the client. The nurse who is providing care bases the healing environment on the therapeutic relationship and the experience of caring behaviours.

The alliance between the human being who can be either a caregiver or the client, and the nursing fraternity permits the experience of the curing association. On similar note, the collaboration between the human being and the milieu offers an occasion to put together all characteristics of the human being as the course of action of curing. While the health is encountered when there is an interface of constituents of person, healthcare is not restricted to the nonexistence of the poor health but also includes religious living being. The reciprocal action is not easy but multifaceted as it incorporates the interior

and exterior human being features and the collective internal and external objective features. Each of these interacting aspects requires to be taken into consideration when just beginning the curative affiliation.

Recognition of curative association utilising the implementation of the ten curative progressions is crucial. The transpersonal caring instant, that is an additional component of the Watson human caring theory, is comprehended by means of the shared accomplishment amongst the settings, healthcare and execution of the nursing ideology for example compassionate. The caring moment does not occur spontaneously but requires the active practice of the caring healing modalities (Watson 2008:10).

3.5.1 Human being /person (patient and the nurse)

Watson (1988b) classifies the person as a living organism in the biosphere, who grips three domains of existence intelligence, physique, and soul; that is influenced by personality and who is exclusive and liberated to generate options. This philosophy emphasises the interrelation amongst the creature and the milieu. The caregiver during the data collection must enquire about the clients' context or milieu (relatives, customs, society, the general public assets within the neighbourhood etc.). The caregivers should be concerned about how their clients relate to the environment. The creature is impacted by the interior and exterior surroundings and human being and combined features, which follows hereunder:

3.5.1.1 Internal-individual subjective factors

Isolation refers to the separation from the physical and non-physical environment where a person feels unwanted by the people around her. Lived experiences: inform the references for the expectations in an encounter with the similar situation. Such references (good or bad) may lead to the barriers of the relation and connection between the two people.

Internal motivation: the willingness to benefit from the connection/relation comes from within and what the next person has been to create an environment that will enable the expression of feelings and requesting help.

3.5.1.2 Individual – external objective factors

Heredities: the constitution of human being will have an effect on the individual character in the affiliation irrespective of the being there or nonexistence of challenging atmospheric features. Intellectual growth: the grade of information and insight of a personage's in the associations may affect the dynamics of the affiliation. Psychosomatic growth: the condition of intelligence at the time of relation will affect the grade of association amongst the dual persons in the affiliation. Physiological physique matter: corporeal features for example pain could obstruct the capability of the caregiver to hook up with the client (Makua 2014: 80-91).

3.5.1.3 External-collective and inter-objective factors

Assemblage partisanship: discrimination such as grouping individuals for example “sex workforce and truck drivers” direct judgemental outlook thus precluding the association essential to permit the curative course of action. Patriotism: the ethnic group that you belong to; will affect the keenness to bond to the other human being thus deter the ordinary therapeutic progression. Employment: certain types of occupations place persons far above the ground position thus holding back the want to articulate the uncertainties and terror. Caregivers require not to shed tears in the event of bereavement, for the reason that she is familiar with the circumstances from an operational setting. Domestic constitution: domestic unit configuration, that permits assured individuals to conclude, may obstruct the relationship; there might be uncertainties to execute association pending getting permission from family decision makers (Makua 2014: 80-91).

3.5.1.4 Collective-internal and inter-subjective factors

Religious conviction: approval of the denunciation of correlation between the two individuals may also be connected to the apprehension of contravention the spiritual values in the course of action of interaction with the next individual. False notion: pessimistic false notion such as (HIV positive male should have unprotected sexual activity with a virgin for them to be cured of HIV) may show the way to extreme repression of emotions and the necessity for assistance. Morality: what the public overlook as tolerable conduct may not automatically profit the two individuals in the affiliation. While the caregiver has the ethical responsibility to enlarge the keenness to assist, the client should apply ethical accountability to present his obstacles to the caregiver (Makua 2014: 80-91).

3.5.2 Nursing

Watson (1988b: 54) defines nursing as “human being discipline of individuals and individual health, infirmity experiences that are arbitrated by proficient, individual, scientific, artistic and principle individuals care dealings”. This author views nursing as both the art and the science. Watson argues that to be an artist is a measure of the caregivers’ accountability and measure of compassion for clients and loved ones. Watson (1999) illustrates the imaginative sphere of nursing as emergent transpersonal caring-curing technique. Such transpersonal caring-curative technique keeps up a correspondence to offering soothe ways, assisting the cared-for to lessen agony, tension, and affliction, as well as to encourage well-being and curing. Watson (1988b) recognises consideration as the real meaning of nursing. This author supplements that compassion can be regarded as the caregivers’ ethical principle of preserving human decorum by supporting an individual to discover connotation in infirmity and affliction to reinstate or uphold the individual’s synchronisation. Watson’s (1999) current description comprises consideration as an exceptional manner of existence-in-relative with an individual’s personality, with others, and the wider surroundings.

3.5.2.1 Internal – individual subjective factors

Empathy: defined as “an expression of one’s sorrow at another’s plight” (Morse, Bottorf, Anderson, O’Brien and Solberg 2006: 79).

Caring intent: the objective of caring is to help individuals accomplish an advanced level of organization within the mental, physical body and spirit, that yield self-awareness, self-satisfaction, independence, and self-help progression whilst increasing diversity (Watson 1985: 49).

Utilisation of information: Watson in the carative process clarifies that permitting the natural world to transpire must be prepared in the viewpoint of proficiency and perceptive of the professional.

Conservation of self-worth: Regardless of the condition of well-being “fatal or comatose,” the need to respect the dignity of the person demonstrates the caring character.

Therapeutic existence: once the patient is approaching death and no medical assistance is available for him, the attendance by the compassionate qualified personnel offers the expressive curing of the individual (Makua 2014: 80-91).

3.5.2.2 Individual – external objective factors

Experience: it forms the lived past and will be linked inter-subjectivity in the present in order to allow the process of healing to occur as explained in the transpersonal caring theory.

Operational circumstances: the work period that the caregivers are at work and the period of the diurnal influence the grade of collaboration amongst the caregiver and the client. The amount of work and the stress of period restrict the curative association amongst the caregiver and the one cared for. Health position of the caregiver: caregivers require being bodily and expressively in

good physical shape to generate a healing setting for the clients (Makua 2014: 80-91).

Communication expertise: Morse *et al.* (2006: 77) clarified the communiqué reactions if the caregiver displays the skill of communication and displaying sympathetic intuition to the motivations as associated, reproduced and qualified reply.

3.5.2.3 External – collective and inter-objective factors

Information administration: Concealment and admiration of the individual's confidentiality must be valued to put up with the affiliation/ association, which will be proven by the trusting relationship. Harmonisation of compassion: Clients that attend the amenities for doctor's appointment will display a lack of courage if they have to narrate all again with every appointment. Appropriate recommendation to extra crew affiliates for continuousness of circumspection will boost teamwork. Usage of assets: progress of tending expertise must be used for balancing nurse training not substitute the compassionate ethics for the nursing career. Encouragement: caregivers as being at the heart of the treatment strategy of the client require advocating for the requirements of clients and not merely gratifying the predictable everyday jobs to release the warning signs (Makua 2014: 80-91).

3.5.2.4 Collective – internal and inter-subjective factors

Relations: caregiver and the client must take part in the decisive association utilising mutual curative goalmouth to generate an atmosphere, which might permit the 'wonder' to take place. Admiration: Reciprocated admiration forms the credulous association and permit communication of adverse and affirmative feelings. Traditional proficiency: the variety of values stresses appeal from the caregivers to learn the rudimentary traditional intimations that will boost the communication with the clients. Imposing the cultural values on the patient may result in failure to achieve the healing goal. Usage of linguistic: The usage of linguistic varieties from vocabulary, intonation,

articulation of confrontations and usage of exaggerations. The necessity to strive for transparency for the duration of communication will boost the progress of a healing association (Makua 2014: 80-91).

3.5.3 Environment

Setting denotes to the societal, psychosomatic, expressive issues that might influence the conditions of the well-being of a human being (Jarrin 2012: 18-22). Watson (2001: 347) argues that generating curative milieu whatever stages (corporeal over and above spiritual), an understated milieu of drive and awareness, in which totality, attractiveness, well-being, self-respect, and concord are indicated. Supporting with rudimentary necessities, through international consideration cognizance, administering human consideration fundamentals, that indicates the alignment of mind-body-spirit, comprehensiveness, and harmony of existence in all facets of compassion; attention to in cooperation the personified soul and developing divine occurrence. Foundational and presence to spiritual-mysterious and existential proportions of one's own life/death; soul care for self and the one-being-cared-for (Watson 2001: 347).

3.5.3.1 Internal – individual subjective factors

Outlooks: the critic approach is damaging to the formation of the therapeutic affiliation. Subjective principles: what works for one person does not always work with the next. Beforehand proposing or recommending the client on any phase, decide the shared standards that you part with the client as a caregiver. Confidence: The duty of caregiver in the curative affiliation is to infuse confidence and optimism in the client (Makua 2014: 80-91).

3.5.3.2 Individual – external objective factors

Watson (1999: 254) revisited the concept of Nightingale's idea of milieu and deliberated how the therapeutic milieu can endorse the individual's alertness and realisation and inspire mind-body-spirit totality and therapy. Hygiene:

setting in which the collaboration is happening must be neat, prepared and unrestricted from the hindrances to inspire individual that is asking for backing to bond with a caregiver. Apartment hotness: Excessively warm or excessively icy surroundings impede the well-being of dual persons that are interrelating and occasionally disturb the manner of communication and veil the unexpressed announcement indications, which may direct progression. Bright: Through collaborating with a client, the intelligence of the ability to see is correspondingly significant to deliver communication to the receiver (Makua 2014: 80-91).

3.5.3.3 Exterior – collective and inter-objective factors

Party-political influences: circumstances of politically aware variability in the capacity or state may lead to the feeling of unsafe during the communication thus extracting significant info useful in affiliation. Influences for instance racism might generate barriers in association amongst the caregiver and client. Usual catastrophes: Disaster management and where there are more people in necessity of assistance than persons who are accessible to offer assistance, period influence and prioritising might obstruct capability to attach to a client. Monetary influences: the centuries of financial breakdown in which all distinct is striving to stay alive, providing guidance that is reliant on the currency source might result to impracticable curative strategy amongst client and caregivers (Makua 2014: 80-91).

3.5.3.4 Communal – interior and inter-subjective factors

Social standards: Commanding issues since the public that commands anything on a social basis tolerable or not for instance unravelling, masculine and feminine responsibilities in the domiciliary have an impact on the sustenance that may be contributed to client. Discrimination: Independent conventional views around ethnicity may halt association amongst caregiver and client. Although happening individual-to-individual collaboration concerning being repressed but social compression might have an emotional impact on the association amongst caregiver and client. Bigotry: indigenous

beliefs males are higher to females therefore regardless of the role that the nurse with all the knowledge is playing above everything she remains a woman thus will not therapeutically connect with male patient. Class struggle: archaeologically, physicians inhabited upper level than caregivers, transmitting to the public point that it must be a physician who is suggesting a course of therapy, not the caregiver (Makua 2014: 80-91).

3.5.4 Health

Watson (1985: 48) argues that health is well defined as the “accord and synchronisation inside the thoughts, physique and emotion.” Healthiness is connected with perceived self to the perception of experienced self. According to the WHO healthiness is not simply the absenteeism of illness however, comprehensive corporeal, intellectual, and societal welfare (Watson 2012: 1).

3.5.4.1 Interior – individual personal issues

Individual connotation: distinct finest describes excellence of healthiness therefore requests used for healthiness is exclusive amid entire persons. Singular wants to discover subjective denotation of anything healthiness is to her and not to the universal public of clients. Religiousness: association amid physique thoughts and soul (Watson 2012: 31) is accentuated in the excellence of consideration that desires to be provided to clients. Sensations: conception of expressive intellect denotes proficiency to recognise reactions and direct such excitements devoid of the aching ensuing individual. Introspection: a person requires simplifying his judgement of healthiness to tolerate to accept recommendations from caregiver, who is an expert (Makua 2014: 80-91).

3.5.4.2 Individual – external objective factors

Research laboratory investigations: unbiased trials from surveys will accurately decide ones' grade of healthiness, irrespective of ones' feelings. Raised blood sugar levels and hypertension are considered as great danger

symbols although the consumer may not sense some corporeal variation in their well-being circumstances. Announcement of that information amongst caregiver and client could direct to the difference in the description of well-being, intruding to the association amongst the dualistic. Tension managing: owing to socio-economic standing in the biosphere, pressure converted to daily trial. Numerous surviving approaches, categorised as encouraging wellbeing (public discussion), and individuals that are not encouraging well-being (dealing). Flexibility: Conferring to rudimentary human desires directive of the stage, the capability to come across rudimentary desires is reliant on motion stage of a person. Diminished movement owing to infirmity, an individual develops eternally incompletely reliant on the next person. Protection: Long-lasting illnesses for instance Diabetes Mellitus, malignancy, inflammation of joints and HIV/AIDS diminishes the resistance stages of persons, hence dropping healthiness and exposes them to other disorders that might result in a syndrome. Bodybuilding and relaxation: balance amongst bodybuilding and relaxation progresses body fluid flow and metabolic rate physiologically, therefore preserving the equilibrium. Dietary prominence: insufficient diet directs to expressive unpredictability of persons directing to bad temper however, extreme nourishment guides to the way of life illnesses for instance stiffness of joints, that might lead to immobility (Makua 2014: 80-91).

3.5.4.3 Exterior – collective and inter-objective factors

Sustenance clusters: Sustenance may be obtainable from volunteers of a community (NPO), to assist client handle ailment effectively. Healthiness indemnification: affordable costs of healthiness indemnities permit a person to devise a right of entry to the progressive multifaceted action remedies, which may advance healthiness position. Preventive medicine structure: Primary Health Care is the initial phase of maintenance must be capable to achieve every illness during a timely stage to decrease expenditures associated with subsequent stage of compassion. Spates: plagues of illnesses, for instance, MDR, XDR and TB, are airborne infections, a stance the healthiness hazard

to the community and might signify terror of contagion amongst healthiness experts, therefore, upholding space from clients inhibiting association mandatory to permit healing association (Makua 2014: 80-91).

3.5.4.4 Shared – internal and inter-subjective factors

Connotation of delivery: Supreme societies ascribe confinement to the sentiment of Divine remuneration; the aforementioned must not be prohibited regardless of healthiness hazard anticipated. Connotation of bereavement: some persons observe passing away as penalty from Divinity, it is ill recognised in relations and time and again they strive to deal with the forfeiture and results in different circumstances of psychological healthiness for example hopelessness. Intelligence to fit in prejudice and public exclusion founded on the disorder of healthiness of person directs to deprived compliance and defiance to a curative design by the affected individual (Makua 2014: 80-91).

3.6 THE CARATIVE PROCESSES

The carative factors were invented in 1979 and modified in 1985 and 1988b, Watson view “the carative factors” as the main centre of caring. This author utilise phrase carative to differentiate with conservative medication’s remedial influences. Carative influences endeavour to “respect humanoid proportions of tending’s duty and interior presence earth and idiosyncratic expertise of personalities deliver provision (Watson 1997b: 50). The carative influences are encompassed of 10 essentials:

- Creation of human centred-self-sacrificing structure of principles.
- Installation of confidence-hopefulness.
- Refining the sympathy to person and other human beings.
- The expansion of the human care association of helping and trusting.
- Systematic usage of technical problematic-resolving technique for verdict constructing.
- Advancement of transpersonal instruction and erudition.

- The delivery of a compassionate, defensive and/or remedial psychological, corporeal, societal and divine setting.
- The support with the satisfaction of human essentials.
- Permission for pragmatic-intentionality-mystical-enigmatic and pragmatic magnitudes of the individual's lifetime-demise, souls' consideration for personality and the patient (Watson 1988b: 75)..

Watson (2001: 347) established her philosophy and later familiarised the notion of scientific caritas progressions, which substituted carative features. This author elucidated that concept "Caritas" emanates terminology, denotation to appreciate and contribute distinct affectionate consideration. The caring association is essential by mutually carer and healthcare user to uphold the therapeutic tradition. If caregivers are interested in converting their career, they will need the change of perception and put into practice deliberate activities of altering the training from within moving towards the outside (Watson 2009: 146). The subsequent are Watson's transformation of carative features into experimental caritas progressions:

3.6.1 Creation of humanistic-altruistic organisation of principles

This is supposed to remain "practice of loving-kindness and composure within the perception of caring consciousness". What clients bring to the affiliation of caregiver and client is affected by their religious values and own existence practice. It also gives you an idea about that not only the expressively troubled individuals necessitate psychoanalysis but every human being. The recognition of the personality by the other human being leads to the enhanced sense of worth, self-reliance and self-sustenance (Tomey and Alligood 2006: 149). The caregiver is likely to perform affectionate kind-heartedness and care for the wellbeing of self and others. Caregivers have ethical accountability and commitment to propose compassion that is of extraordinary excellence to the client (Watson 2001: 347).

3.6.2 Installation of faith-hope

Watson (2001: 347) argues that installation of faith-hope becomes “being genuinely present, facilitate and satisfying the profound faith system and subjective world of self and one-being-cared-for”. The issue defines caregivers’ responsibility in the institution of efficient caregiver-client inter-association, which may encourage the welfare of the client. Association may help the client in assuming healthiness pursuing conduct. Once no treatment plan can be executed to assist the client, the caregiver may support clients’ faith, respect clients’ way of life and honour clients’ values. The caregivers are capable of focussing on that client at a certain point (Carusso, Cisar and Pipe 2008: 128).

3.6.3 Cultivating the sensitivity to the self and others

Refinement of compassion to an individual’s personality and other persons is supposed to remain “development of one’s religious custom and transpersonal self, going beyond ego-self.” Caregivers have accountability to advance expressive intellect. Caregiver must be considerate and compliant with her judgment so that she will be able to help the client to discover his emotional state. Recognition of one's emotional state will direct to the accomplishment of self-discovery requisite. Caregivers recognise their kindliness; convert to authenticity and acknowledging clients’ decision (Watson 2001: 347).

3.6.4 The development of the human care relationship of helping and trusting

Improvement of a serving, trusting and human caring connection becomes “initial and nourishing a serving, innocent, and genuine caring affiliation.” The expansion of a trusting connection must be grounded on philosophies of life rational, truthful, sincere and authentic. For that reason, a caregiver must not only reveal understanding to a client but also attain expertise to get ahead of consideration of clients’ circumstances. Features for example gesture,

expression, eye contact and facial appearance perform responsibility in the development of the credulous association (Watson 2001: 347).

3.6.5 Advancement and approval of manifestation of optimistic and adverse emotional state

The capability of caregiver to remain calm even if the client is annoyed, the caregiver should reveal the capability to embrace the patients' feelings. The obligation of caregiver to inspire the client to express their emotional state. The pace at which a patient displays their emotional state may vary and requires tolerance on the part of the caregiver (Watson 2001: 347).

3.6.6 Methodical usage of technical problematic-resolving technique for pronouncement construction

Inventiveness in development clients' maintenance may necessitate aspiration to discover and determine methodologies that builds on the exclusive characteristic of clients (Carusso, Cisar and Pipe 2008: 128). Curative usage of personality by the art of involving the client in the progression of generating compassionate-curative training is indispensable (Watson 2009: 44).

3.6.7 Promotion of transpersonal teaching and learning

These are viewed as "engaging in genuine teaching-and learning experience that attends to the unity of being and meaning attempting to stay within other's frame of reference". The determination of the distribution of thoughts and practices amongst the caregiver and client may direct to well-being-therapeutic-wellbeing training ideal. Coaching and knowledge acquisition milieu does not need to be official at all times, however, may take place in the progression of communication amongst caregiver and care receiver. Each caregiver-client encounter should offer development of both caregiver and client (Lukose 2011: 28). In the event in which teaching is official, the

caregiver must attempt to remain in the clients' belief system (Watson 2001: 347).

3.6.8 The establishment of a compassionate, protecting and/or counteractive psychological, corporeal, social and mystical setting

Providing of a helpful, defensive and/or remedial psychological, physical, social and divine milieu, becomes "generating curative atmosphere at all levels – physical and non-physical, a subtle atmosphere of energy and consciousness, whereby inclusiveness, beauty, comfort, dignity and peace are potentiated". Apart from divine, social and cultural issues, elementary issues such as relaxation, confidentiality and well-being will inspire the delivery of compassionate atmosphere for the client. Creation of counteractive atmosphere is not restricted to the corporeal atmosphere, on the other hand rather encompass spiritual for instance emotion of belief. Milieu must be diplomatic, reassuring and about the self-esteem of the client. Permitting clients to prepare anything possible to assist in generating compassionate and independent surroundings (Watson 2001: 347).

3.6.9 The assistance with the gratification of human needs

Support using the satisfaction of human requirements is seen as helping with rudimentary desires, with a deliberate caring realisation, managing human upkeep fundamentals that enhance the configuration of the physique, thoughts and soul, totality and harmony of existence in entire features of compassion, inclining to mutually personified soul and developing mystical appearance. Nurses have the responsibility to enquire from the patient if there are any challenges for the patient requires assistance with the basic needs, they should be provided with respect such as minimising unnecessary exposure of the patient because he is unable to dress himself. Caregiver must embrace deliberate, compassionate awareness of moving the exemplified soul (Watson 2001: 347).

3.8.10 Allowance for existential-phenomenological-spiritual-mysterious and existential dimensions of one's life-death, souls care for self and the one-being-cared-for

Watson (2011: 47) refers that as an opening and attending to the spiritual mysterious, unknown and existential dimensions of pain, joys and suffering, transitions of life change, life and death to unfold as a miracle.

Noddings (1984) avers that there are four fundamental constituents in coaching compassion. They are (a) modelling, described as demonstration of caring for the learner nurses to learn how to care; (b) dialogue, that includes open-ended exchange and discussed behaviour that reveals caring; (c) opportunity to practice caring; and (d) confirmation or feedback to the caring event. Scholars argue that the culture of compassion is built by going through considerate connections with NEI in a setting sustained by optimistic considerate NEI-learner associations (Eley, Eley, Bertello, and Rogers-Clark 2012; Gaines and Baldwin 1996; Tanner, 1990; Watson 2008). Figure 3.1 illustrates how the researcher has adopted the four above-mentioned components by Noddings (1984) to formulate the theoretical framework and design for this study. The details of how the model was used to guide the study were provided in the main study.



Figure 3.1: Noddings' (1984) Caring Models in Teaching

Noddings (1984) argues that inspecting several cases of caring associations identified the following characteristics in all of them:

- The carer is attentive; that is the carer adopts an open, receptive attitude toward the cared-for. The author used the concept engrossment to refer to this attitude of no-selective receptivity. But attention will do, if there is understanding that the initial attention is not directed by self-interest or preconceived values. These interests and values may indeed enter the picture eventually, but initially the carer's attention is non-judgemental, open, genuinely focused on what-is-there in the other's message.
- The carer experiences motivational displacement; that is, her motive energy-at least temporarily-flows toward the expressed needs of the cared-for. This is diversion of energy under the demands of caring. Sometimes, the displacement is resisted, and then the caring relation is

at risk. Displacement is properly resisted, because the expressed need is unethical or is thought to be against the best interests of the cared-for. In such cases, the relation is still at risk, and the carer has the task of persuading the cared-for that his expressed needs are, in some sense, wrong. The carer in these cases must still try to maintain the caring relation, although the caregiver cannot respond positively to the expressed need.

- The carer must act. Using the information supplied by the cared-for and whatever resources available, acts to satisfy or modify the expressed need. The ethic of care cannot tell us exactly what to do. Whatever the carer does must support the caring relation without doing harm to anyone in the web of care (Nucci and Naraez 2008: 168).

Nodding's model based on care ethics consists of the four components discussed hereunder:

3.8.10.1 Modelling

Almost all approaches to moral instruction acknowledge the importance of modelling. For educators to instil learners to be moral individuals, educators ought to demonstrate moral behaviour for learners to copy. For caring perception, instructors must demonstrate to them what it means to care. Facilitators demonstrate their caring by listening to learners and providing them respectful courtesy to their communicated needs. When their attempts at caring fail to connect or elicit a response of gratitude that the caring has been received- they initiate encounters designed to learn more about the learners' needs and the backgrounds from which they have arisen. They talk, listen, explain, negotiate and sometimes back away watchfully, recognizing that their efforts may have been too insistent, even intrusive (Nucci and Naraez 2008: 168-169).

It is important to note that, although educators necessarily model caring, caring instructors do not care primarily for the sake of modelling caring. The modelling is an inevitable by-product of genuine caring. It is for this reason that care ethicists are a bit sceptical about caring behaviours. When researchers list caring behaviours and set out to study them, care ethicists want to know what triggered a particular behaviour. Does it represent a caring response to a need or want expressed by the cared-for, or is it simply a behaviour chosen from an approved list of caring behaviours? If it is best described as the latter, then its status as a caring response is in question. A smile, a positive remark to a learner's faulty presentation, a pat on the shoulder may or may not be a caring act. Even listening, if it does not agree to what what-is-there in the learners may not be a caring performance. Every caring act must be assessed in context. There are times when facilitator's attention is focused on the effect of their modelling. When the facilitator treats a classroom infringement with organisation consideration, their attention may be as much on the lesson they are providing for the whole class as on its effects for the wrong-doer (Nucci and Naraez 2008: 169).

3.8.10.2 Dialogue

Dialogue is the most essential constituent of moral education from the care perception. All forms of moral education use talk of some kind-usually statements of knowledge, commands, rebukes, praise, warnings, advice. However, dialogue involves a mutual search for understanding. The conclusion is not known to one party at the outset and then gradually revealed to the other. Parents and educators sometimes engage children in such a fake form of dialogue. They talk until the adult lays down the law, perhaps saying that they tried to reason with the young ones. In contrast, a caring adult who feels it is necessary to insist on a pre-decided outcome will say so immediately there will be no deception at dialogue. True dialogue involves a topic of considerable interest to at least one of the parties, and it is open-ended. Together, the parties in dialogue search for meaning and understanding. Such dialogue differs from most everyday conversation in its

purpose-that search for meaning and understanding. Such dialogue differs from most everyday conversation in its purpose-that search for meaning and understanding. It is not trivial chi-chat. A dialogue may be fluctuating by intermittent intervals of discussion. A caring participant may, change the subject temporarily if she sees that the cared-for is suffering or uncomfortable with the direction dialogue has taken. Adults often interrupt the flow of logical reasoning in dialogue to assure a youngster that he is rational, to jog his memory that he has efficaciously controlled a similar state of affairs, or that all persons suffer miseries of indecisiveness. The discussion may even deviate to ruminations, anecdotes, or playful activity with words. To do this well, partners in dialogue must have a grasp of interpersonal reasoning. The caring relation is more important than the chain of reasoning that should culminate in a logical conclusion (Nucci and Naraez 2008: 171-172).

Constructive criticism may emerge in dialogue, but it is not allowed to damage caring relations. Genuine dialogue also has the potential to restore the “immortal conversation” to education. Through discussion, individuals also learn more about their own motives and what matters to them. Exchange of ideas should be preferred to moralistic education on the qualities. Readiness to go into discussion is essential to the conservation of particular associations. Dialogue at home and academic institution can reduce the need for rid rules, penalties, and many acts of coercion (Nucci and Naraez 2008: 171-172).

3.8.10.3 Opportunity to practice caring

Learner nurses learn to care first, by being cared for. Nursing students observe as caring is modelled, and they explore moral life through dialogue. Student nurses need opportunities to practice caring. Every human encounter presents an opportunity to care, and moral education should emphasize this. Classroom procedures should create situations in which caring can be encouraged and monitored. Group work can provide opportunities to care and to strengthen the whole web of care. However, if group work is to be effective, teachers must continually remind learners that they are engaged in this work

to help one another- not simply to produce a better product or surpass another group. Young ones, like all human beings, can be very unpleasant to one another. If, for example, they will receive a group grade for their work, they may pick on the weakest members of the group and divert their own attention from caring to compete. It is hard to maintain care and trust in a climate of competitive grading, and educators must use some ingenuity if they are to get the best from group work. Caregiving is not always accompanied by caring, but opportunities to help others may encourage caring. Service learning is, therefore a promising arena in which to practice caring but, again, participation must be carefully monitored, and supervisors should be sure that learner nurses listen to those they are serving and that expressed needs are heard. It cannot be considered practice in caring, if learners are directed simply to perform pre-specified tasks that may or may not meet the needs of those designated as care receivers. The association between caregiving and caring should be discussed in dialogue. There is some evidence that women take more naturally than men to caring as a moral orientation, in part because they have been expected for centuries to take responsibility for caregiving (Nucci and Naraez 2008: 174).

Most instructors nowadays agree that females as well as males should have experience with building materials, mathematical games, and science experiments, but we often neglect our male children when it comes to apprenticeships in caring. Practice in working together provides an opportunity to develop social skills, and well-developed social skills in turn contribute to a life of caring and being cared for. It is far easier to work with, cared-for, or accept care from a pleasant, well-mannered individual than an inconsiderate, grouchy one. Working together under the supervision of caring educators also makes it more likely that learners will develop healthy peer relationships and the hope is that success in such relationships will assist to build a caring society (Nucci and Naraez 2008: 174).

3.8.10.4 Confirmation/ Feedback

Confirmation, as I have discussed it in care ethics, does not appear in most other models of education. The aforementioned concept refers to a carer's conscious act of affirming or confirming the morally best possible motive consonant with reality. Such acts are not mere strategies designed to manipulate the cared-for (Nucci and Naraez 2008: 174).

3.9 TRANSPERSONAL CARING RELATIONSHIP

Watson (2012: 76) argues that psych synthesis considerate association be contingent on numerous issues as defined beneath:

- The ethical obligation to defend and boost human pride.
- Caregiver must possess the expertise to acknowledge and determine temperaments and acquaintances to a client (emphasis).
- Caregiver must be keen to approve prejudice, the divine importance of the client.
- Caregiver to feel a human-to-human association with the client.
- Caregiver capacity to utilize her combined history to envisage the client's emotional state and distress from numerous human circumstances.
- Caregiver capability to utilize the strength of affiliation to create contemplative manner needed for compassionate and sustenance to be assumed to the client.
- Caregivers' talent to incorporate personal know-how and sentiments with unprejudiced interpretations of circumstances.
- Caregivers' capability to establish skill of compassion by audible range, seeing, and be talented to know-how the emotional state of the client (Watson 2012: 76).

3.10 PERCEPTION OF THE WATSON'S CARING THEORY

Caregivers work in different sociocultural and socio-political milieu, so it would be imprudent to suggest a template of behavioural expectations and performance evaluation. Routine tasks and conservative nursing may be all-inclusive if carer applies carative factors (Lukose 2011: 28). Watson for that reason claims that the absence of sufficient groundwork of caregivers in psych synthesis nursing, will possibly lead to clashes amongst caregiver and clients (George 2011: 413). Caregiver client association is progression, that develops by phases to attain determined profit to mutually gatherings. Features, for instance, hope, assurance, compassion, backing, erudition, receiving of state of mind will govern the type of association amongst healthcare providers (George 2011: 316). Unemotional predisposition in which caregivers instrument stable manner of performance and regularly assuming dictatorship approach may not assist the mutual process of problem solving for both the nurse and the patient (Watson 2008: 108).

Halldorsdottir (2008: 644-646) in a research paper intended on discovering underlying forces of caregiver-care receiver affiliation and caring practices, the situation was obvious from clients that, rendering compassion is not proficiency linked to the performance of a sequence of responsibilities but rather the involvement of divine association amongst health care provider and client. Similar positioning of thought is shared by Watson considerate philosophy, with more emphasis on the soul-to-soul association to generate caring moment. Caritas progression methodology in caregiver client association may support the management of inadequacies linked to nursing process and signal grounded tactic, that was later perceived as a substitute to old-style Era I and II of nursing (Watson 2008: 113). In the Caritas procedure, the caregiver is allowed to draw all forms of knowing in a creative, individualised way that embraces theory, ethics, morals and sound clinical judgement.

3.11 APPLYING THE CONCEPTUAL FRAMEWORK IN THE STUDY

The theoretical framework provides consideration for the best technique of resolving difficulties, which direction to pursue and the association between the variables in the research (Grant and Osanloo 2014: 16-17). Miles and Huberman (1994: 440) state that it encompasses philosophies, conventions and principles to guide the research. Those theories come from the greatest practices in the exploration literature associated with enhancement of the caring attributes amongst the nursing students and newly qualified professional nurses' co-operative (Grant and Osanloo 2014: 17).

It offers a reasonable construction of interlinked concepts that depict how ideas relate to each other in a theoretical framework (Grant and Osanloo 2014: 17). The contextual framework applies to the research problem, the literature review, investigation techniques and analysis of data (Grant and Osanloo 2014: 22). The conceptual framework should be associated with the literature review by concept mapping defined as the progression and organisation of philosophies (Grant and Osanloo 2014: 19). It offers a structure to direct the investigation approach, interpretation of results, and discussion and reporting of the results (Kelly 2010; Grant and Osanloo 2014).

The qualitative phase was to assess the nursing students', newly graduated professional nurses, nurse managers (including clinical preceptors, mentors, deputy managers and unit managers) of those facilities where the nursing students and newly graduated professional nurses (less than five years) are allocated, and nurse educators', comprehension of conception human caring to explore the intrinsic and extrinsic factors related to the development of human caring attributes from their perspectives. Secondly, to determine the nursing students' and newly graduated professional nurses (less than five years of experience) experiences in both the theory and the clinical setting that has contributed to the development of human caring attributes.

3.12 ERUDITION

Collins (2009: 614) believes that scholarship transpires through lifetime and must not be regarded as 'preparation for existence' however fairly as 'fragment of existence'. Description of Commission of a Nation of Lifelong Learners is utilised by Collins (2009: 615) and is along these lines:

- Learning is a continuous supportive process which stimulates and empowers individuals to acquire all the knowledge, values, skills and understanding they will require throughout their lifetimes and to apply them with confidence, creativity, and enjoyment in all roles, circumstances and environments.

Collins (2009) additionally breakdowns this explanation into lesser fragments clarifying it along these lines:

- Unceasing (at no time discontinuing).
- Compassionate (it is on no occasion prepared unaccompanied).
- Inspiring and allowing (it is self-reliant and vigorous, not submissive).
- Integrating acquaintance, standards, abilities and comprehension.
- Covering a lifespan (it occurs since our birth to death).
- Pragmatic (it's not just for information's sake).
- Integrating self-assurance, resourcefulness and pleasure (it's an optimistic, satisfying involvement).
- And comprehensive of all persons, surroundings, and settings (it relates not only to our elected career but to our complete existence) (Collins 2009: 615).

Muller (2004: 291) argues that 'scholarship is an interior pursuit', whose consequences is behavioral modifications. Knowles *et al.* (2005:10) affirm that learning is a process that results in a change in behavior, knowledge, skills and attitude with the emphasis on the learner in whom change takes place. Knowles *et al.* (2005: 10) further makes a distinction between learning and education. Education is the action intended to effect change in knowledge, attitudes and expertise with emphasis on the educator who presents the

stimuli and reinforcement for learning and transformation. Collins (2009: 614) upholds that characters cannot interpret “the end of obligatory schooling with relief or value liberty from scholastic compulsion more highly than the continuance of envisioned education”. For knowledge acquisition to become prosperous, some philosophies require consideration.

3.12.1 Principles of learning

Designed for learning to remain fruitful, learners need to memorize given facts by scrutinizing knowledge of the subject matter and owning it to make sure that the information will be valued (Poell and van der Krogt 2013: 1). In opinions of Fink and Osborne (1992: 61) and Muller (2004: 292), the following philosophies of knowledge acquisition and learning assist to improve learning.

- Amount of inspiration demonstrated by student connects straight with a technique that pupil combines new details, ideas, expertise and principles. A student should show eagerness to study by displaying curiosity, enthusiasm and intelligence of accountability.
- Vigorous participative learner tends to display a higher quality of learning than the passive, uncomplicated proficient learner. Vigorous contribution comprises performance-needed training and demonstrating a “precarious critical assertiveness” by probing queries, contributing in considerations and narratives, expressive of newly achieved capability, and behavioral transformation.
- The use of difficult resolving tactics is inclined to boost inspiration as well as vigorous contribution and thereby facilitates learning.
- Repetition results in improved memory of information; especially if the reinforcement comes because of usage of the new information.
- Reward and feedback encourage valuable scholarship; particularly if the prize is internalized which means that the learner has to ask him-or herself: “How does this aid me?”
- Usage of multi-sensory gestures, (for instance, seeing and hearing) is helpful during the learning.

- Scholarship positive atmosphere in-unit plays a significant role in the learning process.

Moreover, for a scholarship to be prosperous educator needs to be accustomed to numerous scholarship spheres. Diverse scholarship spheres are drawn in the following section.

3.12.2 The erudition realms

Taylor and Hamdy (2013: e1562) concur with Lesner, Sandridge and Newman (2011: 29) who claim that experimental actions/ learning necessitate three learning domains: intellectual, psychomotor and affective. Bloom's Taxonomy of learning breaks these domains up into progressively from simple to more complex stages, where each stage must be understood before progressing to the next. An overview of the six cognitive learning domains is set out in Table 3.1 below: first level one being knowledge: The scholar can recall and establishes that has been memorised, and the last level six is evaluation: The scholar is capable to make quantifiable or subjective judgments constructed on a reasonable argument.

Table 3.1: Cognitive Domain

COGNITIVE DOMAIN		
Taxonomy level	Definition	Examples of taxonomy verbs
Level 1: Knowledge	The scholar can recall and establishes that has been memorised.	<ul style="list-style-type: none"> • Define • List • Record • Repeat
Level 2: Comprehension	The apprentice holds connotation and can interpret from one form to another.	<ul style="list-style-type: none"> • Compute • Describe • Explain • Restate • Review
Level 3: Application	The beginner can utilise the info in a new state of affairs.	<ul style="list-style-type: none"> • Demonstrate • Interpret • Solve • Use
Level 4: Analysis	The pupil can examine conceptions, breakdown them down into constituent fragments and realise configurations in them.	<ul style="list-style-type: none"> • Analyse • Categories • Compare • Contrast • Differentiate
Level 5: Synthesis	The pupil can put info organised in an exclusive tradition to resolve glitches.	<ul style="list-style-type: none"> • Arrange • Create • Formulate • Prescribe
Level 6: Evaluation	The scholar is capable to make quantifiable or subjective judgments constructed on a reasonable argument.	<ul style="list-style-type: none"> • Assess • Evaluate • Rate • Revise

As observed in Table 3.2 below, an overview of the seven psychomotor learning domains is set out. These domains consists of seven stages with advancement from modest to multifaceted. The first level =one being

perception: the apprentice can use sensual prompts associated with motor performances. Last level= seventh being origination: pupil can generate new motor performances or techniques of influencing object:

Table 3.2: Psychomotor Domain

PSYCHOMOTOR DOMAIN		
Taxonomy level	Definition	Examples of taxonomy verbs
Level 1: Perception	The apprentice can use sensual prompts associated with motor performances.	<ul style="list-style-type: none"> • Distinguish • Hear • See • Touch
Level 2: Set	The student is equipped to respond to intelligent, physical, and/or communicative cliques	<ul style="list-style-type: none"> • Adjust • Locate • Place • Prepare
Level 3: Guided response	The pupil is capable to emulate the performance of alternative being and through experimental and mistake recurrence until the presentation is accurate.	<ul style="list-style-type: none"> • Copy • Duplicate • Imitate • Repeat
Level 4: Mechanism	The educated reaction converts characteristic and the gradation of expertise escalations.	<ul style="list-style-type: none"> • Adjust • Build • Manipulate • Mix
Level 5: Complex overt response	The apprentice is expert and accomplishes without uncertainty and with harmonisation.	<ul style="list-style-type: none"> • Calibrate • Demonstrate • Maintain • Operate
Level 6: Adaptation	The pupil can transform drive decorations to appropriate new circumstances.	<ul style="list-style-type: none"> • Adapt • Change • Develop • Supply
Level 7: Origination	The pupil can generate new motor performances or techniques of influencing object.	<ul style="list-style-type: none"> • Construct • Create • Design • Produce

As observed in Table 3.3 below, an overview of the five affective learning domains is set out. These domains consists of five stages with advancement from simple to complex. The first level =one being receive: The pupil is aware and enthusiastic to direct consideration and last level= fifth being internalise: The beginner performances dependably in accord with morals that is cohesive into a total way of life or worldview.

Table 3.3: Affective Domain

AFFECTIVE DOMAIN		
Taxonomy level	Definition	Examples of taxonomy verbs
Level 1: Receive	The pupil is aware and enthusiastic to direct consideration.	<ul style="list-style-type: none">• Accept• Attend• Realise• Recognise
Level 2: Respond	The pupil accumulates with propositions, is enthusiastic to react, and answers with gratification.	<ul style="list-style-type: none">• Behave• Cooperate• Obey• Observe
Level 3: Value	The pupil consents a worth as a confidence and follows the importance.	<ul style="list-style-type: none">• Accept• Believe• Prefer• Seek
Level 4: Organise	The pupil intellectualises a worth and categorises a worth system into a well-ordered affiliation.	<ul style="list-style-type: none">• Organise• Demonstration• Approval• Dispose
Level 5: Internalise	The beginner performances dependably in accord with morals that is cohesive into a total way of life or worldview.	<ul style="list-style-type: none">• Incorporate• Substantiate

Source: Lesner, Sandridge and Newman (2011: 29-32)

3.12.3 Learning styles

People learn using different techniques and learn in different ways (Pashler, McDaniel, Rohrer and Bjork 2009: 106). Grownups acquire knowledge in diverse techniques and are capable to modify techniques in which study to suit surroundings and subject content (Mohanna, Cottrell Wall and Chambers 2011: 49; Taylor and Hamdy 2013: e1561). Mature students cultivate the first choice for knowledge acquisition that is designed for the duration of and grounded on childhood learning. Vollers (2008: 28) opinion is that learning is a skill. Beischel (2013: 228) cited that learning style influences learning. Lesner *et al.* (2011: 29) argue out that no universal learning style tends to be influenced by various factors such as personality, intelligence, culture and sensory and cognitive preferences. Beischel (2013: 228) affirms that an individual's learning style can positively or negatively affect learning.

Numerous approaches have been defined concerning scholarship; however, it cannot be determined that one is better than the other (Vollers 2008: 28). All representations are worthwhile when bearing in mind that the perception of learning styles (Mohanna *et al.* 2011: 49). According to Vollers (2008: 40), the better an educator's comprehension of scholarship the better the instructor's direct exertion to develop scholarship progression. Pashler *et al.* (2009: 108) and Baykan and Nacar (2007: 160) confirms that scholarship may be unsuccessful or effective on condition that pupils obtain training which does not think through their scholarship styles. Russell (2006: 350-352) cited that utmost often utilised technique to distinguish amongst scholarship styles is through describing photographic, aural and kinaesthetic pupils as discussed in the section below:

3.12.3.1 Photographic students

Pictorial beginners study best by visual subject matter and for that reason images and metaphors are supportive to these pupils helping an improved understanding of philosophies and information. Photographic learners characteristically recite the assumed information and as they work and benefit when illustrations or images are included. Photographic beginners frequently aspire to learn through mind maps, or similar techniques to remember sequence of events; these learners usually organise their learning materials carefully (Felder and Soloman 2000: 3; Russell 2006: 351-352; Graf, Kinshuk and Liu 2008: 484; Arora, Leseane and Raisinghani 2013: 80).

3.12.3.2 Acoustic students

Acoustic students learn best by listening to information. The aforementioned have a predilection of an educator or individual to chat to them regarding explicit information. They recall spoken information well through spoken reiteration and by saying or reiterating information out loud (Baykan and Nacar 2007: 158). Auditory learners frequently favour deliberating on the facts, which they do not instantaneously comprehend and in general find it hard to work silently for long periods of time. These pupils are often easily

diverted by sound as well as quietness; this is the group of individuals who usually appreciate collective deliberations (Felder and Soloman 2000: 3); Russell 2006: 351-352; Graf, Kinshuk and Liu 2008: 484).

3.12.3.3 Kinaesthetic learners

Kinaesthetic learners learn best by being physical involved in what is being learned or taught. The aforementioned pupils typically appreciate taking notes to retain full control of activities although they often do not study these transcripts. Kinaesthetic novices frequently have a propensity to remember the specific activity after doing it once and have good motor coordination. Classically, the aforementioned beginners do not gain or prefer traditional speeches or group deliberations lessons (Russell 2006: 351-352 and Baykan and Nacar 2007: 158). Honey and Mumford (cited in Mohanna *et al.* 2011: 49) argues that pupils might utilise a mixture of dual learning approaches, holds individualities of entire foursome learning styles in analogous quantities, or might obligate distinctive of single learning styles. According to these investigators, four learning styles are described as innovative, reflector, and philosopher and practical person novices as deliberated in the section below.

3.12.3.4 Activist learners

Innovative pupils appreciate contributing to innovative practices; they are progressive and eager to attempt everything formerly, flourishing on the encounter of new involvement. These apprentices have a habit of getting uninterested rapidly and want to experience new challenges. Innovative pupils are communicative apprentices and want to be the focus. They study best while innovative proficiencies are presented; small actions complement them; they appreciate circumstances they are able to develop ideas; they flourish when they create new designs and “have a go at things/brainstorm ideas” (Mohanna *et al.* 2011: 49). Graf *et al.* (2008: 483) maintain that active learners desire to process the information actively by doing something with the material, for example, by discussing or testing the information received. Felder and Soloman (2000: 2) and Arora *et al.* (2013: 80) state that vigorous

students tend to approximate cluster exertion; conferring to Felder and Silverman (1988: 678), this announcement is true as they recommend vigorous beginners do not study considerably in circumstances necessitating of them to be inactive.

3.12.3.5 Reflective learners

Reflective learners incline to reflect, contemplate analytically around a condition and gather a huge quantity of information before reaching a conclusion. Normally, thoughtful learners are watchful and take a back seat in assemblies and deliberations; the aforementioned learners preserve a little outline and have a habit of giving the impression of being on top of things (Mohanna *et al.* 2011: 49). Students study best while they are certified to contemplate around actions, deliberate, and are allowed to perform investigations and analyse choices (Mohanna *et al.* 2011: 49). In the position of Graf *et al.* (2008: 483), learners favour to work unaided, an interpretation maintained by Felder and Silverman (1988: 678) reflective learners do not benefit from circumstances that do not allow them an opportunity to think about the information presented.

3.12.3.6 Theorist learners

Theorist learners commonly regulate and assimilate explanations into rational plans and replicas. They are perfectionists and independent workers. Moreover, the aforementioned learners have a habit of rejected information that is subjective. Philosophers learn best when actions consist of strategies, plans and replicas to designate discovery; once given time to determine methodology; once afforded unequivocal determination with a planned state of affairs, and given complex situations to understand. Theorist apprentices study best when they are challenged intellectually (Mohanna *et al.* 2011: 49).

3.12.3.7 Pragmatist learners

Pragmatist learners are inclined to attempt innovative concepts, viewpoints and practices with the purpose of testing if it works in practice. These learners act fast when there are ideas that they are attracted to and are not patient with open-ended tedious discussions. Pragmatist learners have a predilection for resolving problems and try to make real-world pronouncements; they study best when there is a perfect association amongst the information and their profession (Mohanna *et al.* 2011: 49). In the following section, the focus will be on mature learners since nursing students are adults.

3.13 SUMMARY OF THE CHAPTER

The chapter explained and deliberated on the theoretical underpinning of the study, the ten carative influences concerning to the compassionate viewpoint by Jean Watson, adult learning theories, and the four foremost conceptions: nursing, environment, person and health. Based on the literature review and research questions, it showed how the conceptual framework was constructed. It also explained how the constructed framework guided the study. In the next chapter, the methodological presentation of the study is outlined.

CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

The previous chapters delivered the orientation of the study, literature review as well as the theoretical framework of the study. This chapter will present the method applied in the conduct of the research comprising research design, population, sampling as well as the data collection, analysis strategies and ethical considerations.

4.2 RESEARCH DESIGN

Research design comprises established pronouncements concerning what theme is to be investigated, among what population, which research methods will be utilised in the execution of the study and purpose thereof (Barbie 2013: 116). The research design is the overall plan according to which researchers obtain answers to the research questions and handling challenges that can undermine the study evidence. The research design is the architectural backbone of the study (Polit and Beck 2017: 56). The research design is a blueprint for conducting the study that maximises control over factors that could interfere with the validity of the findings (Burns and Grove 2011: 49).

4.2.1 Convergent mixed methods approach

Teddlie and Tashakkori (2009: 4) pronounce the three groups of researchers in societal and behavioural sciences as being qualitatively positioned, quantitatively positioned and mixed methodologists. The research subject and the existing knowledge about it (Brink, van der Walt and van Rensburg 2018: 44) direct the assortment of the technique to use. According to Burns and Groove (2011: 20), quantitative investigations pronounce and scrutinise associations and can conclude causatives among variables, valuable for challenging a model. The quantitative includes logistics, inferential perceptive

as the investigator scrutinises facts to create oversimplifications about the marvel. Polit and Beck (2017: 741) describe qualitative enquiry as the exploration of the marvels characteristically in a comprehensive and all-inclusive approach, through the gathering of the quantifiable description, using a supple investigation strategy.

Qualitative investigation strategy includes a methodical collection of facts in the method of the difference of opinion, which transpire in an ordinary environment. Qualitative enquiry is utilised to discover individuals' experiences, perception, emotional state, opinions, performances and activities (McMillan and Schumacher 2010: 23). It provides an enhanced comprehension of the standpoint of the phenomenon being studied (Knudsen, Laplante-Lenvesque, Jones, Preminger, Nielsen, Lunner, Hickson, Naylor and Kramer 2012: 90). In this study, the qualitative strategy was a productive technique to attain an extensive discernment on the perceptions and understandings of undergraduate nursing students and newly graduated professional nurses (less than five years of experience) in KZN. Qualitative investigation is about investigating the abilities or features of a phenomenon being studies and it about understanding a situation as it unfolds. It delivers a rich and dense depiction of the phenomenon being investigated. Data was gathered in real-life. It manufactured facts that revealed how respondents distinguished, performed, assumed, represented and their perception (Botma, Greef, Mulaudzi and Wright 2010: 182; Polit and Beck 2017: 506). In this investigation, the investigator pursued to critically analyse the role played by theoretical and clinical learning experiences in influencing the development of human caring attributes amongst the undergraduate nursing students and newly graduated professional nurses (less than five years of experience), to establish clear guidelines that can be used by lecturers to enhance human caring attributes. Qualitative denotes the style of investigation in which the properties of the phenomena are assessed to improve understanding (Henning 2004: 35).

The investigator needed a strategy that would integrate all the above abilities to collect the indispensable actualities that would direct her in the establishment of clear guidelines that can be used by lecturers to enhance human caring attributes, and felt using either of the two methods would fall short of the qualities that existed in the other method. Mixed methods are another advantageous strategy, which is obtainable to the investigators and are developing very rapidly because of its advantage of permitting the scholar to take the best of the qualitative and quantitative methods and combine them (Bergman 2008: 11). Creswell and Creswell (2018: 14) define the mixed approaches investigation strategy as the strategy with a theoretical supposition that directs the course of the assemblage and exploration of facts. The research called for a blend of qualitative and quantitative methods in the exploration to be able to respond to the study aims and objectives. Thus, a mixed-methods design was used to conduct the study.

The convergent mixed method design (Qualitative and Quantitative) was used to evaluate essentials from both qualitative and quantitative models due to the interactive characteristic of the research (Streubert and Carpenter 2011: 354). This technique permitted the investigator to utilise contemporaneous technique to instrument the qualitative and quantitative components during the examination prioritise both methods equally, but keep the strands independent and only mix the quantitative and qualitative results during the interpretation process (Creswell and Creswell 2018: 217). The determination of using the convergent strategy was to acquire diverse but harmonising information on the expansion of human caring attributes amongst the nursing students to empower the investigator to attain the greatest potential comprehension of the investigation problematic (Creswell and Creswell 2018: 216). According to Creswell and Creswell (2018: 4), varied approaches investigation is a methodology to analyse connecting gathering both quantitative and qualitative information, incorporating the two arrangements of data, and utilising distinctive enterprises that may encompass theoretical supposition and theoretic frames. The fundamental supposition of this custom of investigation is that the amalgamation of qualitative and quantitative

methodology allows for a better understanding of the research problem. A mixed technique investigation strategy was selected for this research because one information basis will be inadequate to completely respond to the research questions.

Both quantitative and qualitative facts were composed and investigated within a single investigation. The quantitative aspect enabled the researcher to gather information from undergraduate nursing students and newly graduated professional nurses (less than five years of experience) from both KZNCN and DUT using the CBI-42 (Wolf *et al.* 1994) tool. This research instrument was industrialised as a 75-item questionnaire; the CBI-42 is a second-generation tool utilised to amount compassion (Wolf *et al.* 1994). As a consequence of psychometric procedures, the tool was reviewed to a 42 item questionnaire (Beck 1999; Kyle 1995; Wolf *et al.* 1994). The qualitative aspect allowed the researcher to gather information from the newly graduated professional nurses (less than five years of experience) and nursing students' from KZNCN and DUT understanding of the concept human caring, to explore the intrinsic and extrinsic factors related to the development of human caring attributes from their perspectives and to determine their experiences in both the theory and the clinical setting that contributed to the development of human caring attributes through in-depth interviews. Focus group discussions with nurse educators from DUT and KZNCN and nurse managers (including clinical mentors, preceptors, unit managers and deputy managers) from facilities were newly graduated professional nurses (less than five years of experience) and nursing students from DUT and KZNCN practice, also enabled the researcher to gather some rich information from these participants. Table 4.1 presents the research methods used to achieve each objective of the current study.

Table 4.1: Research methods used to achieve each objective in the study

	Objective	Research question	Data collection methods	Approach
1	Assess the nursing students', newly graduated professional nurses, nursing educators' and nurse managers understanding of the concept of human caring.	What is your understanding of the concept of human caring?	Semi-structured interviews. Focus groups discussions.	Qualitative
2	Explore and describe the intrinsic and extrinsic factors related to the development of human caring attributes from the perspective of the nursing students, newly graduated professional nurses (less than five years of experience) and nurse educators.	What is the role played by theoretical and clinical learning experiences in influencing the development of human caring attributes among undergraduate DUT nursing students, to develop guidelines that can be used by lecturers to enhance human caring attributes among the nursing students?	Semi-structured interviews. Focus groups discussions	Qualitative
3	Determine the nursing students' and newly graduated professional nurses (less than five years of experience) experiences in both the theory and the clinical setting that contributed to the development of human caring attributes according to their perspective.	What are your experiences in both the theory and the clinical setting that contributed towards the development of human caring attributes according to your perspective?	Semi-structured interviews. Focus groups discussions	Qualitative
4	Explore and describe the skills and abilities that are needed to be successful at caring from the perspectives of the participants.	Briefly describe skills and abilities that are needed to be successful at caring from your perspectives.	CBI-42 Tool that was adopted after the permission was granted by the author. Semi-structured interviews. Focus groups discussions	Quantitative
5	Investigate the association between the working environment and the development of human caring attributes.	What is your opinion to about the working environment and the development of human caring attributes?	Semi-structured interviews. Focus groups discussions	Qualitative
6	Establish clear guidelines for lecturers and the clinical facilitators to be used to enhance human caring attributes among the nursing students	What would you recommend as additional measures that can be put in place to assist and support nurse educators and nursing students engaging in nursing education and training to improve the quality of patient care?	Based on the findings of all the above	

4.2.2 Philosophical underpinning of the study

The question that investigators ask, and the approaches they utilise to respond to their enquiries, originate from the scholar's opinion of how the realm 'works' (Polit and Beck 2014: 33). Worldviews can be seen as a universal theoretical positioning about the sphere and the natural surroundings of exploration that an investigator takes along to an investigation. The category of principles held by the distinct academics constructed on these features will often lead to a quantitative, qualitative, or mixed approach in their investigation (Creswell 2018: 5).

4.3 RESEARCH PARADIGMS

Research paradigms are the framework within which a researcher operates according to their ontological stance, representing: a way of thinking about a subject and proceeding with research that is accepted by people working in that area. This approach attempts to identify not just correlation of phenomena, but causality as well, through systematic reduction and isolation of variables to ascertain an irrefutable causal factor in outcomes (Newby 2014: 46). Thomas Kuhn (1962 cited in Johnson, Onwuegbuzie and Turner 2007: 130) popularised the idea of a paradigm. Research paradigm means a set of principles and suppositions that a community of academics has shared concerning the natural surroundings and demeanour of investigation. The philosophies comprise, but are not restricted to ontological philosophies (it is the truth that works), epistemological beliefs (association amongst academic and contributor), axiological principles (the ethics of the investigator), aesthetic and methodological principles. In short, a research paradigm refers to a paradigm: qualitative research, quantitative research, and mixed-method research (Johnson, Onwuegbuzie and Turner 2007: 131). The usage of these theoretical suppositions in this mixed-method research study assisted the researcher in conducting the qualitative and quantitative phases of the study.

Mixed method research is often associated with pragmatist paradigm (Tashakkori and Teddlie 2010: 15). According to Polit and Beck (2017: 578), a model is a way of observing ordinary phenomenon that incorporate a theoretical assumption controlling one's method to probe. Mixed techniques have been defined as studies that are yields of the practical person model and that associate the quantitative and the qualitative methods within the diverse stages of the investigation (Tashakkori and Teddlie 2010: 15).

In this worldview, multiple methods of data collection are used to answer the question(s) being studied. Pragmatism is a school of thought that originated from North America by historical figures such as John Dewy (1858-1952), William James (1842-1910) and Charles Sanders Pierce (1839-1914). The word pragmatic is a Greek word derived from "pragma" meaning work. For an idea to be true, it must be shown to work. It focuses on the consequences of research; is problem-centred, pluralistic, and oriented towards what works and stresses the real-world practice (Creswell and Creswell 2018: 10-11). To the pragmatists what is "true" is what "works"? Originally there have been two research approaches: the quantitative and the qualitative approaches supported by two paradigms, which are positivism/post-positivism and constructivism (Teddlie and Tashakkori 2009: 15). Practicality is in general considered as the logical partner for the mixed method and which differentiates the tactic from virtuously quantitative tactics that are founded on a viewpoint of a post (positivism) and virtuously qualitative tactic that is founded on a viewpoint of (post) interpretivism or constructivism (Johnson, Onwuegbuzie and Turner 2007: 126).

A mixed-method approach emerged as the third research approach with pragmatism as the third paradigm. There were debates and arguments with the emergence of the mixed-method approach. Researchers following the first two approaches argued that it is impossible to mix the quantitative and the qualitative approaches because of the different philosophical underpinnings which are incompatible, it is either a qualitative approach or a quantitative approach, hence "the incompatible thesis" (Teddlie and Tashakkori 2009: 15).

The mixed-methods researchers with the introduction of pragmatism rejected this either qualitative or quantitative war. The pragmatists countered the incompatibility thesis by posting that it is possible and acceptable to mix quantitative and qualitative methods if the research required the use of the two methods to answer the research question(s) (Teddle and Tashakkori 2009: 73). The rudimentary features of practicality are the denunciation of whichever or optimal amongst constructivism and positivism, and the pursuit for real-world responses to queries in which the investigator is fascinated (Teddle and Tashakkori 2009: 86). Paradigms are grounded on three dimensions; namely; epistemology, axiology and ontology.

- a. Epistemology pertains to the knowledge of reality and what is accepted as knowledge. In this study, both quantitative and qualitative data collection approaches were used to triangulate data and ensure that the question being asked is answered fully. The qualitative approach (semi-structured interviews and focus groups) was used to better understand the results of the quantitative approach (CBI-42 questionnaire) so that there is a deeper understanding of the problem by the researcher.
- b. Axiology describes the role of values of the researcher, which are vital in conducting research and during the interpretation of the results (Teddle and Tashakkori 2009: 90). The pragmatist researchers study what is important within their personal value system. The researcher in this study has the vast clinical nursing experience, has taught undergraduate nursing students for so many years, and has a passion for it. She also has experience of being a patient in both public and private healthcare institutions. The researcher believes that the lives of the communities can be improved through the revival of the values of the nursing profession namely enhanced caring attributes, communication skills and emotional intelligence and competence amongst the nurses at all levels. If this reality can happen, it affects positively on the patient outcomes and there will be a decline in lawsuits in both the public and government healthcare centers.

- c. The ontology describes the nature of reality. Pragmatists concur with positivist about the existence of an external reality independent of our minds and deny that truth about reality can be determined (Teddlie and Tashakkori 2009: 92). According to these authors, it is “the truth is what works”. The use of mixed methods research assisted the researcher to obtain in-depth knowledge about the theoretical and the clinical experiences of the participants in the study on the question asked through conducting the research using the approach (CBI-42 questionnaire for the quantitative strand and using the semi-structured, individual interviews and focus group discussions for the qualitative strand. The research questions asked by the researcher were answered more clearly and precisely.

4.4 STUDY METHOD AND DESIGN

A convergent mixed methods design (Qualitative and Quantitative) was utilised to assess elements from both qualitative and quantitative paradigms due to the behavioural aspect of the study (Streubert and Carpenter 2011: 354). This technique permitted the investigator to utilise synchronised scheduling to instrument the qualitative and quantitative components during the similar investigation progression, line up both approaches correspondingly, but preserve the components autonomously and simply combine the quantitative and qualitative consequences for the duration of the inclusive analysis (Creswell and Creswell 2018: 217). The determination of utilising the convergent design was to attain diverse but corresponding information on the expansion of human caring attributes amongst the nursing students to permit the investigator to attain the greatest imaginable comprehension of the research problematic (Creswell and Creswell 2018: 216).

According to Creswell and Creswell (2018: 4), mixed approaches investigation is a methodology to examination including gathering both quantitative and qualitative information, mixing the two methods of information, and utilising

distinctive strategies that may include metaphysical supposition and theoretic frames. The fundamental supposition of this system of question is that the amalgamation of qualitative and quantitative methodologies delivers a more comprehensive comprehension of an investigation problematic. A mixed technique exploration strategy was selected for this investigation because one information foundation will be inadequate to completely response the investigation interrogations. Moreover, the outcomes of the qualitative data may be necessitating explanation, henceforth the quantitative and the qualitative phase of the study will be done simultaneously. The merging of data enabled the researcher to gain an understanding of the intrinsic and extrinsic factors related to the development of human caring attributes. The researcher thereafter transformed the qualitative data set to assess the extent of each theme that emerged.

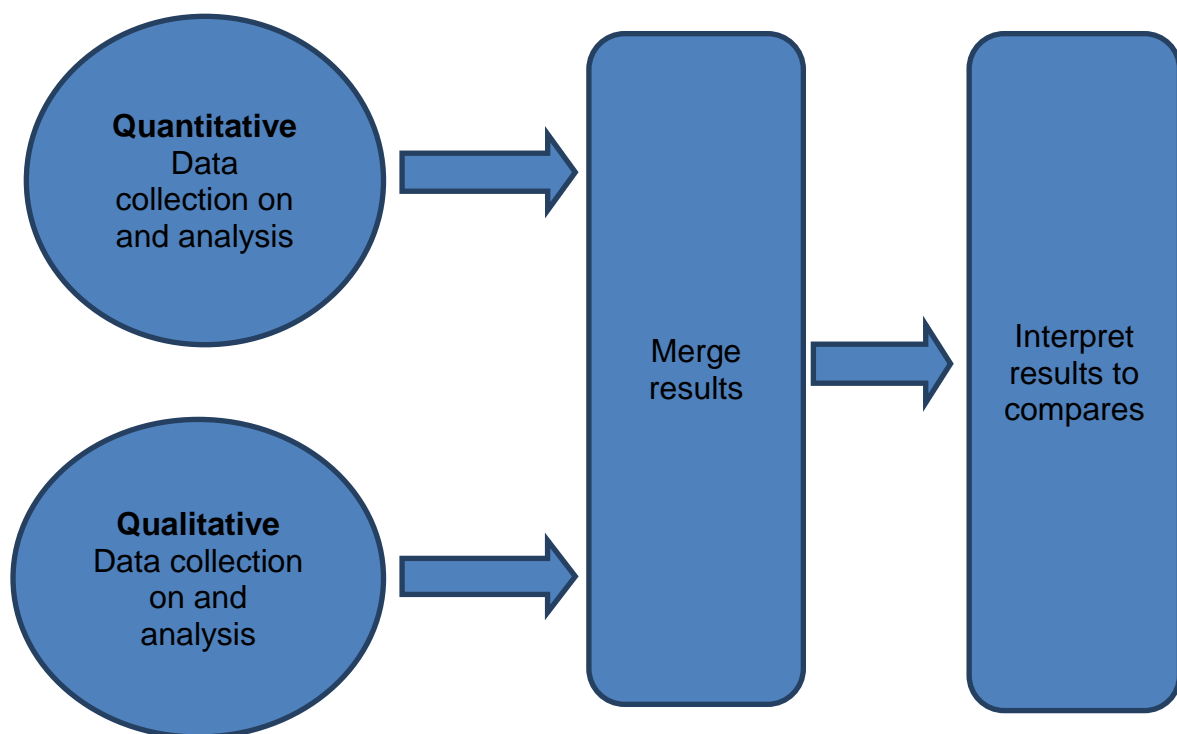


Figure 4.1: The convergent (one phase) design

Source: Creswell and Creswell (2018: 218)

4.4.1 The priority of the quantitative and qualitative strands

The nature of the study called for the quantitative and qualitative phases to be given equal priority. Creswell and Creswell (2018: 220) refer to priority as referring to the relative importance or weights of the quantitative and the qualitative methods for answering the study's questions of which they distinguish between equal, quantitative or qualitative priorities.

4.4.2 Determining the timing of the quantitative and qualitative strands

Timing refers not just to the time of data collection but also to the order in which the researcher will use the data (Creswell and Creswell 2018: 238). These authors differentiate between concurrent, sequential and multiphase combination timing (Creswell and Creswell 2018: 237). The study was conducted using convergent parallel timing, implying that both strands of the study were conducted during one single phase. The investigator utilised synchronised scheduling to instrument the quantitative and qualitative components for the duration of the similar stage of the investigation progression, ranked the approaches similarly and set aside the two components autonomous for the duration of investigation with the intent of mixing the facts during the inclusive analysis (Creswell and Creswell 2018: 236-238).

4.4.3 Mixing of data sets: Determining when and how to mix data sets

Creswell and Creswell (2018: 219-221) distinguished between four distinct levels at which data sets can be mixed, these include mixing during interpretation, during data analysis, during data collection or at the level of design. Mixing happens at the point of the interface also well-known as the juncture of amalgamation, a point within the progression of investigation where the quantitative and qualitative components are mixed (Creswell and Creswell 2018: 219-221). Data mixing for the current study was done during data interpretation. The researcher first analysed each strand of data. By comparing the results of the two strands the researcher was able to draw

conclusions or inferences that reflected how the human caring attributes develop and the experiences of the nursing students and newly graduated professional nurses as well as the experiences of the nurse educators and nurse managers in both the theory and the clinical setting that contributed to the development of human caring attributes. The researcher learned from the quantitative strand what are the skills and abilities that are needed to be successful at caring from the perspectives of the nursing students and newly graduated professional nurses (less than five years of experience) from both NEIs understudy. Combining the two results assisted the researcher to conclude the establishment of clear guidelines that could be used by lecturers to enhance human caring attributes among the nursing students.

4.5 RESEARCH SETTING

Polit and Beck (2017: 744) describe the setting as the physical location and conditions in which data collection takes place in a study. This study was conducted in the province of KZN. KZN is a garden province of South Africa and is a subtropical region of lush and well-watered valleys washed by the warm Indian Ocean. It is located South East of the country and sharing three other provinces and the countries of Mozambique, Swaziland and Lesotho. KZN is divided into eleven districts: Amajuba, Zululand, uMkhanyakude, uThungulu, uMzinyathi, uThukela, iLembe, eThekweni, uGu, Harry Gwala and uMgungundlovu where DUT is situated. KZN is one of the nine provinces in South Africa and has 11 health districts, eight of which are classified as rural districts (KZN Department of Health 2001). Pietermaritzburg is the capital city of KZN and has a population of 500 000. The study will be conducted in three settings namely: Durban University of Technology (DUT), Indumiso campus, KZNCH and in the public health facilities of KZN.

1) The University of Technology

Indumiso campus is one of the three universities in KZN province that are accredited by the South African Nursing Council to provide the four-year undergraduate degree course (R425). This university of technology (UoT) is

situated in KZN province in Pietermaritzburg, uMgungundlovu district. Indumiso campus is situated at Imbali which is a semi-urban township about five kilometers from the city center. The UoT has been chosen for this study because it is the only university of Technology in the area that offers nursing training and in particular. The UoT undergraduate nursing department has adopted the case-based learning approach to enhance learner outcomes and critical thinking in the delivery of the theoretical and clinical content. Clinical competence at the selected UoT is assessed through continuous assessment of smaller tasks during the semester. At the UoT; the evaluation tool for clinical competence is the workbook and midwifery register. These were issued to each student before clinical placement and need to be completed as case-based evidence of their learning. In these workbooks are clinical learning objectives developed by the clinical team of the UoT, based on the SANC regulations for the training of nurses and midwives that the nursing and midwifery student is expected to achieve (South Africa 2005: 4).

2) Three public health facilities from three health districts

Three health districts will be selected to represent individuals from the inner setting, ensuring there is a representation of the northern, southern and midlands districts of KZN. Three health districts were selected to represent individuals from the inner setting, ensuring there is a representation of the northern, southern and midlands districts of KZN. The districts that were purposively selected were uMgungundlovu, eThekweni and uThukela districts. One health institution per district which also had a greater number of newly graduated professional nurses from both institutions understudy was chosen. The choice of two tertiary institutions and one district institution was also based on the possibility of getting different results since these two tertiary institutions are located in the urban area and this district hospital is situated in the rural area. The three selected health facilities are Greys, King Edward VIII and Estcourt hospitals.

EThekwini district

EThekwini district has an estimated population of 3.5 million people, which is the largest of all 11 districts. King Edward VIII is the second-largest hospital in the Southern Hemisphere, providing regional and tertiary services to the whole of KZN and Eastern Cape. King Edward VIII is a 922 bedded hospital with the plus or minus 360 000 outpatients. The hospital is situated in ward 33 in eThekwini district. King Edward VIII is a teaching hospital for the Universities of KwaZulu-Natal's Nelson R Mandela School of Medicine and has a Nursing college attached to it with the following post-basic nursing specialities: orthopaedic, ICU/Critical Care, paediatric and advanced midwifery.

UThukela district

The UThukela Health district has a population of 699 762 and comprises of five local authority areas. The District has one Regional Hospital, three District Hospitals, 36 primary health care facilities, 24 fixed clinics and 14 mobile clinics. There are also nine local authority clinics in the District. This study will be based in a public-funded rural hospital situated in the northern-western corner of KZN province at Estcourt in South Africa. Estcourt Hospital provides all basic health services that are rendered by other district hospitals. It was built in 1922 and is made up of north wing and south wing. There are 11 clinics under this hospital. It also has a referral system, patients are referred to Ladysmith Hospital, Greys Hospital and Inkosi Albert Luthuli Academic Hospital etc. this hospital has 650 employees. There are seven wards in the hospital and 329 usable beds.

The UMgungundlovu district

The UMgungundlovu district is a second-largest municipality in KZN and has rich and multifaceted usual surroundings with abundant assets, comprising old-fashioned countryside societies, unceremonious countryside dwelling areas and high-class metropolitan regions. UMgungundlovu constituency has

inhabitants of 1 095 865 and encompasses seven local authority regions. The foremost metropolitan in the region is Pietermaritzburg, which are both the capital city and the parliamentary capital of KZN I. The district provides illustrious edification amenities and retirement amenities for older inhabitants. It also provides exceptional honourable, marketable and healthiness amenities. It is a significant industrialised, wooden, dairy and agronomic centre that has an up-to-date, classy substructure with easy entrance to the landing field, the N3 principal and railway station. This study was conducted at Greys Hospital. Greys Hospital is a referral hospital providing 20% regional and 80% tertiary services located in Pietermaritzburg, which falls in the UMgungundlovu health districts. Tertiary services are offered to the Western part of KZN I this includes five health districts with a total population of 3.5 million. The hospital has 530 commissioned beds and is presently utilising 494 beds.

3) KZN CN

KZN CN is a public nursing college that is accredited by the South African Nursing Council and is administered under the Department of Health in KZN. KZN CN comprises 25 sites that are made up of 10 campuses offering the R425 nursing programme, where six are situated in urban areas and four in rural areas. The 10 campuses are situated throughout the KZN Districts. It is affiliated by contractual agreement with the KZN Department of Health and the Universities of Kwa Zulu-Natal and Zululand. The study was conducted in four of the 10 campuses that provide the four-year diploma course (R425) programmes. The study was conducted in four randomly selected campuses from KZN College of Nursing at the Zululand, eThekweni and uMgungundlovu Districts. The selected campuses were Addington, Edendale, RK Khan and Ngwelezane. The KZN CN campuses were clustered according to their location that is urban, semi-rural and rural to provide variance in results because of differences in staffing patterns and infrastructure. Four campuses were randomly selected. The participants were those nursing students that were registered for the R425 programme and their nurse educators. The 2nd,

3rd and 4th-year learners were used in the current study because they provided a better insight into the questions and had the expertise and the experience to respond to the questionnaire. The sample size was determined with the assistance of the statistician and 100 learners will be randomly selected from the two campuses, about 30 learners from level 2 and 3 and the total number of all nursing students from other two selected campuses with the total number of less than 100. All the lecturers 100% (n=30) nurse educators that were lecturing the four-year diploma course (R425) were included in the sample.

In South Africa, nursing has traditionally been taught at Nursing Colleges that were affiliated to hospitals and/or universities. In 1986 there was an introduction of the four-year nursing diploma/ degree in several universities and Universities of Technology which are regulated by the Department of Higher Education and Training (McKune 2011: 1). In this study, a nursing programme refers to the four-year undergraduate degree/ diploma programme of training leading to registration as a Nurse (General, Psychiatry and Community) and Midwife which has been offered by DUT at Indumiso since 2011. Nursing programmes require students to be allocated in clinical placement facilities that are accredited by the South African Nursing Council during the whole period of training with minimum clinical hours to be completed. According to SANC (1985 as amended: 3), the minimum clinical exposure is 1000 hours per annum. This is monitored using the clinical hour sheet that the student and the preceptor that is working with the student signs. DUT is accredited for 100 students per annum. There are specific learning objectives which nursing students must achieve to ensure their competence in the clinical in correlation to their theory content. Professional nurses who are qualified and experienced in different fields of specialization employed by the clinical facility to guide nursing students during clinical placement. They are called clinical preceptors or facilitators. Clinical facilitators from the university are responsible for clinical accompaniment and competency assessment of the students. Clinical competence is the potential capacity to perform in a given situation (Dickerson and Chappell 2016: 1).

4.6 POPULATION AND SAMPLING PROCESS

A population is a particular group of people or type of element that is the focus of the research (Burns, Gray and Grove 2013: 351). For this study, the population includes:

1) The undergraduate nursing students who were registered for the Bachelor of Health Sciences in Nursing at DUT. The total population was about 430 students and the target population from DUT (Indumiso campus) was 300 as there were about 100 nursing students in each level of study for the quantitative study. The undergraduate nursing students were purposively selected from the sampling frame. Polit and Beck (2017: 741) describe purposive sampling as when a researcher decides purposely to select subjects who are judged particularly knowledgeable about the issues under study. The target population was all the undergraduate nursing students who are in their 2nd to 4th level or 5th level of study (in case of extended curriculum programme (ECP) and all the academic staff. The researcher excluded first level nursing learners from the study because the data collection will take place from February to June 2019, when their course commenced in February for DUT learners. For the qualitative semi-structured interviews, eight undergraduate nursing students from the UoT were included in the study until the data saturation was reached.

2) The nursing students from the four selected KZN CN campuses were registered for a comprehensive four-year undergraduate diploma (R425). KZN CN comprises of 10 campuses. The study was carried out on four of the 10 campuses that provide the four-year diploma course (R425) programmes. KZN CN is located in the uMgungundlovu District, which includes the city of Pietermaritzburg. The 10 campuses are situated throughout the KZN Districts. Four campuses were randomly selected. The KZN CN campuses were clustered according to their location that is urban, semi-rural and rural to provide variance in results because of differences in staffing patterns and infrastructure. The participants were those learners that undertook the R425 programme and academic staff responsible for teaching this programme. The

total population of 2nd, 3rd, and 4th-year learners vary from 60-157 nursing students in each campus totaling 792 students for the quantitative component of the study. The 2nd, 3rd and 4th year learners were used in the study of. They provided a better insight into the questions because they had been through theoretical and clinical exposure, therefore, had the expertise and the experience to respond to the questionnaire. The sample size was determined with the assistance of the statistician and 100 learners will be randomly selected from two campuses (campus A and campus B), about 30 learners from level 2 and 3 and 40 learners from level 4, the total population of all the nursing students KZNCN for campus C 100% (n=60) and D 100% (n=92). The total number of learners was used because there were less than 100 nursing students available on other campuses. For the qualitative semi-structured interviews, 20 undergraduate nursing students from KZNCN were included in the study. In other words, five nursing students were purposively selected from each selected campus until the data saturation was reached.

3) The newly graduated professional nurses (less than five years) from both institutions understudy, who undertook the comprehensive four-year diploma/degree (R425) and nurse managers (including deputy managers and unit managers) of those three KZN health facilities where the newly graduated professional nurses (less than five years) are allocated were also included in the study. The total population of professional nurses employed by the KZN Department of health N= 15202 and the target population is district A= 5414, district B= 851 and district C=.2589. For this study, 30 newly graduated professional nurses (less than five years) (15 from each institution understudy) were interviewed until data saturation and three to four focus groups of nurse managers (including deputy managers and unit managers) from those facilities where the nursing students and newly graduated professional nurses (less than five years) are allocated. Purposive sampling will also be used to select the study population. According to Pietkiewicz and Smith (2014: 10), this sampling allows the researcher to select a group of people based on preselected relevance to a particular study. Four to five

focus groups of nurse managers per selected institution were conducted in this study.

4) The nurse educators involved in teaching both theoretical and clinical aspects of nursing, working in the three selected campuses of the KZNCN, offering the four-year comprehensive diploma (R425) and the nurse educators from DUT undergraduate degree programme (R425) involved in teaching both theoretical and clinical aspects. The total population of all the nurse educators 100% (n=270) KZNCN and the target population is nurse educators from the three selected campuses that are lecturing the four-year diploma course (R425) were included in the sample, selected from the ten campuses for the research using a simple random sampling method. The total population of N=270 academic staff and the sample size is N=99 (total number of academic staff from the four selected campuses), campus A= 28, campus B= 19, campus C= 31 and campus D= 21. Four to five focus group discussions were held in each selected campus of KZNCN with approximately 19- 31 nurse educators.

The researcher chose this target population from the nursing students and newly graduated professional nurses (less than five years) from both institutions under study because they had completed a year of their training or have been exposed to clinical practice module were be chosen because they have been identified as experts with experience in the field of nursing education and CLE. The principle of data saturation was used to determine the sample size for nursing students. Research indicates that the number of participants to be interviewed using semi-structured interview guides is determined by data saturation. Data saturation is the point at which no new data or new themes can be found. Fusch and Ness (2015: 1409) state that most PhD students interview between 20 and 30 participants for their studies.

4.6.1 Inclusion criteria

- All undergraduate nursing students in their 2nd to 4th level of study for Bachelor of Health Sciences in Nursing at DUT and KZN CN nursing students in their 2nd to 4th level of study.
- All nurse educators who were currently involved in the teaching and facilitation of nursing education at a selected campus in KZN CN or DUT Indumiso campus.
- All newly graduated professional nurses (less than five years of experience) from DUT and KZN CN.
- All nurse managers (including clinical preceptors, mentors, deputy managers and unit managers) of those facilities where the nursing students and newly graduated professional nurses (less than five years) were allocated.

4.6.2 Exclusion criteria

- Nursing students in their first level of study as they had not done the clinical practice module during the data collection period.
- The exclusion criteria for nurse educators were non-availability due to absence from work.
- Nurse educators from both institutions under study (i.e. DUT and KZN CN) who were not directly involved in the mentoring or training of the professional nurses and nursing students who underwent the four-year comprehensive course (R425).
- Professional nurses who qualified from the institution/s understudy more than five years ago.
- Professional nurses and nursing students who did not undergo the four-year comprehensive course.
- Nurse managers who were not directly involved in the mentoring or training of the professional nurses and nursing students who undergo the four-year comprehensive course (R425).

4.7 DATA COLLECTION PROCESS

Data was collected from four different data sources namely undergraduate nursing students, newly graduated professional nurses (less than five years of experience) from DUT and KZNCN, nurse managers (including clinical preceptors, mentors, deputy managers and unit managers). Data collection was done in two phases.

The qualitative phase was to assess the nursing students', newly graduated professional nurses (less than five years of experience), nurse managers (including clinical preceptors, mentors, deputy managers and unit managers) of those facilities where the nursing students and newly graduated professional nurses (less than five years) were allocated, and nurse educators' understanding of the concept human caring to explore the intrinsic and extrinsic factors related to the development of human caring attributes from their perspectives. Secondly, to determine the nursing students' and newly graduated professional nurses (less than five years of experience) experiences in both the theory and the clinical setting that has contributed to the development of human caring attributes. The analysed qualitative data provided the baseline for the investigation of the association between the working environment and the development of human caring attributes in the quantitative phase.

4.7.1 Qualitative phase

4.7.1.1 Instruments, research techniques and procedures

The study utilised in-depth one-on-one semi-structured interviews (Appendix 3b) for nursing students and newly graduated professional nurses (less than five years of experience) from both KZNCN and DUT and also focus group discussions (Appendix 8b) for nurse educators and nurse managers.

4.7.1.2 In-depth semi-structured interviews

In-depth one-on-one interviews were conducted by the researcher with the help of a research assistant. The research assistant was a Masters student who understands research methodology and is fluent in English which is the medium of instruction at both institutions under study. In-depth interviews were aimed at providing rich information on the newly graduated professional nurses (less than five years of experience) and nursing students' from KZN CN and DUT understanding of the concept human caring, to explore the intrinsic and extrinsic factors related to the development of human caring attributes from their perspectives and to determine their experiences in both the theory and the clinical setting that contributed to the development of human caring attributes. However, the interview guide was not used as a rigid structure. Where necessary the interviewer asked to follow up questions for clarification even if they were not included in the interview guide. If issues that were not addressed in the interview guide kept coming up repeatedly during the interviews, the interview guide was amended to include questions around these issues. The interviews were undertaken until data saturation was reached. Data saturation is whereby no new information is obtained from the interviews (Austin and Sutton 2014: 438). The researcher requested for a quiet room or space to conduct the interviews. Permission was sought from the participants to voice record the interview discussions. Each interview session took approximately 45 minutes to one hour to allow for a detailed discussion of the issues.

For the current study, a maximum 30 undergraduate nursing learners were interviewed (15 undergraduate nursing students from DUT and 15 from KZN CN), 30 newly graduated professional nurses (less than five years) (15 from each institution understudy) were interviewed until data saturation was reached. An in-depth conversation is a one-to-one method of data collection that includes an interviewer and an interviewee deliberating precise issues comprehensively. Comprehensive dialogues are utilised when looking for info on distinct, subjective know-hows from individuals about a precise matter

(Hennink, Hutter, Bailey 2011: 109). A questionnaire was used to record the demographic profile of each participant (Appendix 12a). The in-depth one-on-one interview was thereafter conducted. The interview guide contained questions addressing the main research questions. The interview guide was used to facilitate the discussion (Appendix 12b).

4.7.1.3 Focus group discussions

Focus group discussions with nurse educators from KZN CN and UoT and nurse managers (including clinical mentors, preceptors, unit managers and deputy managers) from facilities where newly graduated professional nurses (less than five years of experience) and nursing students from DUT and KZN CN practised. Each focus group discussions were held separately from to ensure diversity of information and to account for the different levels of training. Each focus group discussion had 4-6 participants. The focus group discussions were aimed at getting rich information from nurse educators and nurse managers (including clinical mentors, preceptors, unit managers and deputy managers) on the intrinsic and extrinsic factors related to the development of human caring attributes from their perspectives and to determine their experiences in both the theory and the clinical setting that contributed to the development of human caring attributes. A questionnaire was used to record the demographic profile of each participant (Appendix 12a). The focus group discussion guide was thereafter used to facilitate the discussion (Appendix 12b). Four to five focus group discussions were held with approximately 25 nurse educators from DUT, 25 nurse educators from KZN CN and 25 nursing managers. Each group had a minimum of two participants to allow for a robust discussion on the topic.

To ensure diversity of information, each focus group discussions with nurse educators from university and those from KZN CN, nurse managers (including clinical mentors and preceptors) from the health facility were held separately from each other, to account for the different levels of training and experience. The focus group discussions were held in one of the college/ university's

boardroom. Permission was sought from the participants to voice record the discussions. The focus group took approximately one hour to allow for a detailed discussion of the issues.

4.7.2 Quantitative phase

The qualitative data collection phase was followed by a second quantitative data collection utilising the Caring Behaviour Inventory (CBI-42) after having received permission from the authors (Wolf, Giardino, Orsborne and Ambrose 1994) questionnaire. This quantitative data was collected from undergraduate nursing students and newly graduated professional nurses (less than five years of experience) from both KZNCN and DUT. This tool was initially industrialised as a 75 item questionnaire; the CBI-42 is a second cohort instrument utilised to ration compassion (Wolf *et al.* 1994). Because of psychometric progressions, the tool was reviewed to a 42 element questionnaire (Beck 1999; Kyle 1995; Wolf *et al.* 1994). Mixed methods utilise both prearranged and emergent approaches of data gathering, utilising mutually open and closed-ended interrogations, with numerous methods of data portrayal on all prospects (Creswell 2014: 277). The conceptual-theoretical foundation of this inquiry form was consequential from caring writings in universal and is founded in Watson's (1988) theory of transpersonal caring, within this framework caring is the standard used to measure and interventions (Wolf *et al.* 2003).

4.8 DATA ANALYSIS

4.8.1 Qualitative data analysis

Qualitative data analysis was accomplished concurrently with data collection to discover data saturation. Data were structured and put in storage using the ATLAS TI program. The ATLAS TI program permitted the investigator to capture, systematise and accumulate data into classifications and sub-classifications, themes and sub-themes and to allocate codes. The

prearrangement of data simplified comprehension, clarification and construction of the connotation of the qualitative data.

Tech's open coding tactic was utilised to scrutinise the qualitative data. Tech's method encompasses eight stages of information examination (Creswell and Creswell 2018: 196). The investigator pays attention to audiotapes and also read and re-read all the transcripts to acquire a logic of the entire data and some thoughts were written down as they arose. One transcription of the dialogue was chosen at a phase from the arena transcriptions and read and re-read; fundamental connotations of the facts were organised and written roughly until the investigator fully comprehended the denotation of the facts. Subsequently, the information was scrutinised and analytically discovered to create connotations (Tesch 1992: 141). Significant quotes from the partakers' reactions were recognised; in vivo coding was utilised to present the encounters as survived by the contenders. Information from the arena transcriptions was matched to that on the voice recorder to ensure that all facts had been captured appropriately. Themes according to which to systematise facts were prearranged, directed by the theoretical foundation that was directing the investigation. The information was coded to permit classifying it into sub-themes which were assembled accordingly to previously prearranged themes. The investigator concentrating on groundedness and thickness of facts by defining how many times diverse classifications seemed in the information and connecting the codes to generate connotation.

4.8.2 Quantitative data analysis

Four of the six steps of quantitative data exploration, as pronounced by Burns and Grove (2009: 46), were trailed. These included 1) organisation of information for exploration, 2) explanation of the illustration, 3) evaluating of dependability of dimension and 4) investigative exploration of the facts.

4.8.2.1 Preparation of data for analysis

In this step, data coding and cleaning was done. The first step after data collection was to embark on a data coding where data was transformed into symbols (Polit and Beck 2017: 426). Data was then captured into an electronic spreadsheet. The next step involved the data cleaning process as part of the data quality check to ensure the accuracy and integrity of the data. Copies were made of the original data to ensure that during the data cleaning exercise, the original data were saved and a validity check could be run to identify the changes between the cleaned data and the original data. This process involved checking the data line-by-line and looking for any discrepancies, inconsistencies, inaccuracies and omissions that did not make sense. The changes were categorised as either minor or major changes. Minor changes included 'not applicable' observations not captured appropriately for an example data captured on elements that were not applicable. Major changes would include all records with too many gaps, which would need to be removed.

4.8.2.2 Description of the sample

This step included obtaining a complete picture of all quantitative data collected (Burns and Grove 2009: 462). Comparisons were made between data collected from the different health districts of the KZN Department of Health and also between DUT nursing students and KZNCN nursing students and the newly graduated nurses from the two institutions under study. Description of the study was important because the researcher wanted to compare the findings between the three hospitals managed by different healthcare authorities. Therefore, confirmation was done that data collected from the three healthcare authorities were equivalent in ways important to the study to justify continuing with the study (Burns and Grove 2009: 462).

4.8.2.3 Testing the reliability of measurement

According to Burns and Grove (2009: 222), a measure is a reliable measure if it gives the same results each time the same situation or factor is measured. Although this was ensured first by doing a pre-test and close monitoring throughout data collection, additional evaluation needed to be done before data analysis.

4.8.2.4 Exploratory analysis of the data

All information composed were scrutinised descriptively to become as acquainted as imaginable with the type of information. Each variable was scrutinised to institute that facts were ordinarily dispersed and not twisted (Burns and Grove 2009: 463). The facts from the quantitative inquiry were captured and then scrutinised using version 25 of SPSS. A descriptive, bivariate, and multivariate analysis was used to inspect the association amongst the variables. The backing of a proficient statistician was encompassed for the duration of the analysis stage of the research. The descriptive statistics, comprising means and standard deviations, where appropriate, were utilised, to sum up, the information. Frequencies are symbolised in tables or graphs. A Chi-square goodness-of-fit-test is a univariate test, utilised on a categorical variable to test whether to some extent the reply selections were nominated knowingly more/less often than others. Under the null hypothesis, it was presumed that all replies were similarly nominated (Burns and Grove 2009: 499). The chi-square test of independence was utilised on cross-tabulations to see whether a noteworthy association occurred amongst the two variables represented in a cross-tabulation to see whether a noteworthy affiliation occurred amongst the two variables signified in a cross-tabulation of specific variables. Wilcoxon Signed Ranks Test, a non-parametric test, was utilised to assess whether the usual worth was meaningfully diverse from a value of 3 (the central score). This was applied to queries where replies were recorded on a Likert scale.

The data from the quantitative data set were analysed in two forms. The first analysis included a composite analysis of the entire data set to assess how the two NEI's understudies were performing and secondly comparisons were made of the three health authorities.

4.9 MIXING OF DATA FROM THE TWO STRANDS (QUALITATIVE AND QUANTITATIVE)

The researcher merged data after the analysis to compare results as the study design was convergent. The researcher collected quantitative and qualitative data concurrently. The two data sets were analysed independently using analytic approaches suited for each strand. The results of the two data sets were then compared. The researcher must specify the dimensions by which to compare the results from the two data sets. Further analysis included triangulation and transformation of the data sets and interpreting how the merged results answered the research questions and led to the achievement of the study's objectives.

4.10 TRIANGULATION

All data gathered during the study were triangulated and the results of triangulation are presented in Chapter 7. Tashakkori (2009: 32-33) defines triangulation as a procedure and /or conclusion which includes the mixture and contrast of numerous data foundations, data gathering and or exploration techniques, investigation approaches and insinuations that happen after the scholarship. In this investigation, triangulation was utilised to augment richness to the research and to authenticate nominated characteristics of the manuscript. Bergman (2008: 22-23) contends that triangulation does not denote to the mingling of quantitative and qualitative facts but to testing the legitimacy of a clarification founded on a distinct basis of information by the source to at least one additional foundation that is of a tactically diverse type. Investigator decided to use the process of triangulation with an idea that drawing data from sources that have different potential threats to validity would possibly reduce the chances of reaching false conclusions (Bergman

2008: 23). According to Bergman (2008: 22-27), triangulation is validity checking, indefinite triangulation and triangulation as seeking complementary information. In the current study, data from the observation was triangulated with that from focus groups discussions and with that from semi-structured interviews to achieve two purposes in line with Bergman's stipulations that are triangulation as validity checking and triangulation as seeking complementary information.

4.11 DATA CONVERSION OR TRANSFORMATION

During data analysis, data conversion/transformation was done for the qualitative strand by quantifying it to allow the researcher to do a deeper analysis of the phenomenon under study (Teddlie and Tashakkori 2009: 27).

4.12 DATA INTERPRETATION

Once data analysis had been completed, the researcher needed to develop inferences and meta-inferences by interpreting the study's findings; looking across the quantitative and qualitative results and making an assessment of how the information addressed the mixed method question in the study (Creswell and Creswell 2018: 198). The inferences included conclusions or interpretations drawn from each strand whilst the meta-inferences were drawn across the quantitative and the qualitative strands.

4.13 RESEARCH RIGOUR

The researcher ensured rigour for both qualitative and quantitative methodologies as the two strands are both incorporated in the mixed-method design. The most significant phases in the diverse approaches investigations are when the consequences from the scholarship's quantitative and qualitative elements are amalgamated into a logical theoretical structure that delivers an efficient response to the enquiry question (Teddlie and Tashakkori 2009: 286). The quantitative data required the researcher to address reliability and validity, whilst the qualitative data require the researcher to ensure

trustworthiness. These aspects were incorporated in the conclusions and interpretations that were referred to as inferences and were divided into the process, quality and transferability inferences (Teddlie and Tashakkori 2009: 287).

4.13.1 Inference process

Inference process is described as the process of making sense out of the results of data analysis that includes the entire dynamic journey from idea, to data and to results to make sense of data by connecting the dots. The researcher in the current study stated clearly in the discussion of the results all the steps she followed to create meaning out of the relatively large amount of data collected through focus groups discussions, semi-structured interviews and quantitative questionnaire (Teddlie and Tashakkori 2009: 287).

4.13.2 Inference quality

According to Teddlie and Tashakkori (2009: 27), the aspect of internal validity and trustworthiness are incorporated in the term inference quality. Inference quality refers to the standard for evaluating the quality of conclusions that were made based on both quantitative and qualitative findings. The researcher in the current study ensured inherent quality by observing and keeping track of all processes and procedure required for conducting mixed-method studies and keeping accurate records of all the steps followed during the entire research process in one composite document.

4.13.3 Inference transferability

Inference transferability is an umbrella term that incorporates the terms external validity for quantitative studies and transferability for qualitative research and is measured by the degree to which conclusions from a mixed-methods study might be applied to another setting, people, periods or context (Teddlie and Tashakkori 2009: 27). The researcher in the current study ensured inference transferability by keeping an accurate record of all research

procedures establishing an audit of the trail. In discussing the results and in spelling out the recommendations, the researcher specified the possible through the generalisability of the quantitative strand and the rich and inclusive understanding of the phenomenon created by the qualitative strand (Teddle and Tashakkori 2009: 311)

4.14 RESEARCH TRUSTWORTHINESS (QUALITATIVE DATA)

As qualitative research has a component of bias and is open to denunciation, it is significant that the investigation and the discoveries ought to afford confirmation of legitimacy and dependability (Polit and Beck 2017: 559). Research rigour in qualitative research is related with directness, applicability, epistemological and procedural equivalence, trustworthy observance to a theoretical viewpoint, scrupulousness in gathering information and contemplation of all the facts for the duration of the analysis procedure and the academic's self-awareness (Burns and Grove 2011: 75). Practical consistency was confirmed through accurate recording of all stages and progressions are chosen to perform the research and how the decisions were reached until the construction of an audit trail. Interpretive rigour was ensured by basing the data analysis on the Watsons' Caring Theory as the theoretical framework that was used to guide the study and constantly adhering to the strategies that were inherent within the qualitative design during the data interpretation stage.

Trustworthiness is the confidence a researcher has in their qualitative study and its findings. Its aim is to support the argument that the investigation's findings are worthy consideration. An in-depth description of the trustworthiness is the researcher's sole responsibility, however, its establishment is the responsibility of the prospective researcher who desires to replicate the study (Lincoln and Guba 2985: 301 and Anney 2014: 276)

The investigator utilised an audiotape to make sure that facts were precisely documented and illustrative of the information. Reflexivity was ensured through in vivo coding of data to prevent bias. The verbatim translation of data included no-verbal cues displayed by the study participants during the semi-structured interviews and focus group discussion. Methodological congruence was ensured by conducting extended fieldwork and data were collected for an extended period to ensure accuracy. An audit trail ensured that records were available about the rigorous development of the decision trail by recording all resolutions included in the conversion of facts to the theoretic outline.

Lincoln and Guba (1985: 289) recommended there is an alternate to legitimacy and dependability that would deliver the confirmation for a pronouncement track and reliability to be guaranteed in the qualitative investigation. Dependability denotes to the degree to which research is worth paying consideration to, worth taking note of and the degree to which others are persuaded that the discoveries are to be trustworthy (Barbie and Mouton 2001: 276). Lincoln and Guba (1985: 289) originally recommended four criteria for emerging the dependability of a qualitative investigation, which are believability, reliability, unreliability and generalisability. Later on Guba and Lincoln added authenticity (Guba and Lincoln 1989).

4.14.1 Credibility (internal validity)

Credibility refers to a strategy for evaluating the evaluating the level of confidence in the truth of the data, and it represents the findings of the exploration and description of the theoretical and clinical experiences of the learner nurses and the nurse graduates in order to formulate the guidelines to enhance the development of human caring attributes amongst the nursing student and nurse graduates in KZN (Anney 2014: 276 and Polit and Beck 2017: 559). The investigator ensured credibility of the study through peer group debriefings, member checks, referential adequacy and triangulation of data sources (Lincoln and Guba recommendations 1985 cited in Loh 2013: 5). The detailed notes of the interview were written immediately whilst the voice

recorder was listened to frequently during the transcript of the info, to make sure that accurate data is documented. The similar interview director was utilised throughout the investigation.

Credibility was established through prolonged engagement, persistent observation, triangulation, member-checking, peer-debriefing, structural coherence and the researcher's authority in order to maximise the probability of credible findings in this study.

Prolonged engagement: The researcher has been a nurse educator since 2007 and attended a year-long research methodology course and a six months-long intense pre-doctoral programme. The researcher built rapport and trust and introduced herself to the participants during the debriefing sessions when the informed consent were obtained. The researcher also became immersed in the collected data by listening to the audio tapes and reading the verbatim transcripts repeatedly immediately after data collection (Holm and Severinsson 2013: 3 and Lincoln and Guba 1985:301).

Persistent observation: During the focus group discussions and the semi-structured, in-depth, individual interviews the researcher invested sufficient time to observe, identify and take note of the atypical and salient characteristics and elements that were most relevant to the study and further explored them. All interviews were conducted where participants felt most comfortable, which the settings of the participants' choice, namely: in a boardroom, offices and homes. The facilitative communication clarification techniques were employed during data collection to obtain in-depth experiences and perceptions of participants. The researcher also obtained field notes to record the verbal and non-verbal communication dynamics during the interviews (Lincoln and Guba 1985: 304).

Triangulation is a strategy employed to ensure the accurate representation of reality and to provide corroborating evidence through the use of multiple and different sources (Lincoln and Guba 1985: 305 and Polit and Beck 2017: 747). The quantitative data were collected through the Caring Behaviour Inventory (CBI-42) questionnaire after having received permission from the authors (Wolf, Giardino, Orsborne and Ambrose 1994). The researcher used the focus group discussions, the in-depth, semi-structured, individual interviews and took field notes in order to collect accurate data from the participants. Facilitative communication clarification techniques were also used. During the conceptualization phase, the findings of the collected data were conceptualised within the existing relevant different sources literature.

Member checking was done during data collection when the researcher as an interviewer paraphrased and reflected on the participants' responses in order to verify the researcher's own interpretation of the data being collected. The researcher used verbatim quotations to clearly and accurately portray the participants' perceptions regarding how human caring attributes can be enhanced and to reach conclusions about whether or not final themes were true reflections of participants' comprehensive interpretations. Verification of data was done through the follow-up interviews with two focus group discussions of nurse educators, and two focus group discussion of nurse managers and three in depth, semi-structured, individual interviews with learner nurses and nurse graduates. Member-checking was done to eliminate the researcher's bias during the analysis and interpretation of the interview findings (Anneys 2014: 277; Lincoln and Guba 1985: 314 and Noble and Smith 2015: 34).

Peer debriefing is about discussing emerging insights and tentative themes with research experts during the process of data collection and analysis. Its goal is to explore aspects of research that might otherwise remain only implicit within the researcher's mind (Lincoln and Guba 1985: 308). As research experts agree on the on the fact that data saturation has been reached based on repetitiveness of themes, adequacy of samples size is then ascertained (

Hanson, Balmer and Giardino 2011: 377). The involvement of two supervisors from the conception of the study who are all experts in qualitative research. This was valuable in guaranteeing that the study was credible (Barbie and Mouton 2012: 277 and Loh 2013: 7).

The developed guidelines to enhance human caring attributes amongst the nursing students, was validated the experts that did not take part in the guidelines expansion process, to analyse them for simplicity, interior reliability and suitability in accordance with Thomas (2017: 38) developed guidelines evaluation criteria. Twenty experts ten of whom are PhD holders and are well-versed in guidelines development, qualitative research method and field of nursing education.

Structural coherence refers to affirmation that there is consistency between the data and interpretations in order to enhance the credibility of any argument. There may be interpretations in order to enhance the credibility of any argument. There may be contradictions, which then increase the study's credibility (Anney 2014: 277). The research questions were clearly stated and the research design and method were congruent with the research questions. The focal point of the study was on the development of guidelines to enhance human caring attributes amongst the nursing students and nurse graduates in KZN. The study's language was edited in order to ensure grammatical coherence and to enhance the study's readability (Institution of Professional Editors (IPEd) 2013: 12).

Authority of the researcher: The researcher undertook a one-year research methodology programme and six months intensive pre-doctoral programme, held a Master's degree in professional nursing science, specialising in nursing education and was supervised by two professors who are experts in the guidelines development and qualitative research method. Both professors hold healthcare qualifications, respectively and can confirm the researcher's authority. Literature review provided a thorough understanding of the topic, which placed the researcher in the best position to collect credible data using

skilful, facilitative communication techniques during interviews to gain deeper insights into the phenomenon of interest (Hanson *et al.* 2011: 380).

4.14.2 Dependability (reliability of the data)

Dependability (reliability of the data) refers to the stability of the data over time and conditions (Polit and Beck 2017: 559). The reliability of the data collected during the qualitative phase was ensured through triangulation of the data methods, in which the researcher overlapped the different data methods to ensure trustworthiness. The researcher used an enquiry auditor who was the peer, who then followed the process and procedures used by the researcher in the study and determined whether they were acceptable (Brink, van der Walt and van Rensburg 2018: 155-157).

4.14.3 Confirmability (objectivity)

Confirmability (objectivity) mentions to impartiality that this prospective for correspondence amongst two or more autonomous persons about the information's accurateness, significance or significance (Polit and Beck 2017: 559). The investigator stated on the involvements and the thoughts of the partakers rather than the traits and predilections of the investigator (Shenton 2004: 69). The investigator made use of an investigation examiner to evade prejudice. The academic evaded the inclusion of own clarifications and interpretations by put on the moral guiding principle. Confirmability review piloted to check discoveries, clarifications and commendations sustained by facts (Lincoln and Guba recommendations 1985 cited in Loh (2013: 5).

4.14.4 Transferability (generalisability)

Transferability (generalisability) denotes the degree to which qualitative discoveries can be reassigned to other situations or assemblies (Polit and Beck 2017: 747). The investigator providing a dense depiction of the discoveries of the circumstance for the person who reads to make a knowledgeable pronouncement about the generalisability of the discoveries.

Data were collected and analysed in sufficient detail to provide a baseline understanding for subsequent work to be undertaken, compared and for generalising to the larger population. The researcher offered a clear description of the study context, study setting and research process for the reader to establish the transferability of the results. The researcher further ensured trustworthiness of the qualitative data by efforts to authorise that the discoveries correctly reveal the know-hows and perspectives of partakers, rather than investigators' opinions (Polit and Beck 2017: 747).

4.14.5 Authenticity

Guba and Lincoln (1989) industrialised genuineness principles that could be utilised to assess the excellence of the investigation further than the organisational magnitudes. The academic endeavoured to make certain genuineness by utilising straightforward descriptions by the scholarship partakers. This safeguarded that the sentiment tenor of the investigation respondents was transferred as it was lived experiences by partakers.

4.15 RESEARCH RIGOUR (QUANTITATIVE)

The researcher ensured that strategies to strengthen the quantitative aspects of the study and ways to enhance rigour were adhered to to strengthen the inferences that could be made about cause and effect relationships.

4.15.1 Validity and reliability

Polit and Beck (2017: 742) defined consistency as the accurateness and reliability of facts attained by a scholarship that is often related to the approaches utilised to amount the investigation variables. Consistency was safeguarded initially by espousing an investigation instrument, the Caring Behaviour Inventory tool (CBI-42) by Wolf et al. 1994. The tool was invented by professionals in the arena of nursing and had been used by various researchers and found to be reliable. The study rigour in the quantitative stage of the scholarship was accentuated through the notions of consistency

and cogency of the approaches utilised for data gathering and data scrutiny. The researcher also piloted the instrument with 10 percent of the total sample population to assess the cogency of the instrument in this investigation. The pilot study further ensured content and construct validity demonstrating that the queries were undoubtedly comprehended by the partakers. Any ambiguities or inaccuracies about the questions would have been corrected beforehand issuing the tool to the partakers in the chief investigator. Time taken to complete the questionnaires, which was aimed at 20 minutes, was also be determined. The researcher intended to collect high-quality data using a good psychometric instrument, measuring variables that are accurate and valid. Content legitimacy scrutinises the degree to which the instrument comprises all the main modifications applicable to the concept being appraised. Face cogency authenticates that the tool appeared like it was usable and gave the appearance of evaluating what it was projected to evaluate (Burns and Grove 2011: 335). All data collection tools were structured to obtain the required information and the tools appeared professional and uncomplicated to complete. The data collection tool was tested for face validity during the pre-test.

4.15.2 Homogeneity

The researcher ensured that participants were homogeneous to allow quantitative findings to be interpretable (Polit and Beck 2017: 334). During sampling, the researcher checked for similar and different characteristics. Therefore, the investigator involved learner nurses from two NEIs and newly qualified registered nurses from three diverse health facilities.

4.15.3 Attrition

To safeguard against attrition, the researcher recruited more participants than those required for the sample in the anticipation that some participants could not be available for data collection. Where possible the undergraduates and professional nurses were interviewed on the same day as the information

session, except for those who preferred to make appointments for their interviews on different days.

4.16 ETHICAL CONSIDERATIONS

Investigator sought endorsement from the Institutional Research Ethics Committee (IREC) of DUT. A letter of information (Appendix 3) and informed consent (Appendix 4) were provided to all participating nursing students and newly graduated registered nurses, giving them an overview of the study and their expectations. Respondents were notified that their contribution was voluntarily and that they might pull out at any period without a reason or negative consequences. Confidentiality was adhered to by referring to participants by numbers. To ensure further confidentiality the data was used by the academic only and transcribing of recorded interviews were done. All hard copies of data were kept safe by the investigator and will be destroyed after three years. Dialogues were recorded using audiotape and transcriptions will be made during and immediately after each interview.

4.17 SUMMARY OF THE CHAPTER

In this chapter, the various investigation contexts, study designs, population and sampling, data collection, the study instrument, pilot study, data analysis, trustworthiness and rigour of the study were dealt with. This chapter provides a presentation of both quantitative and qualitative data findings. In the next chapter, the quantitative results are offered in the amalgamation of photographs and themes.

CHAPTER 5: QUANTITATIVE RESULTS

5.1 INTRODUCTION

This chapter provides a presentation of the quantitative data findings. The quantitative results are presented in the combination of graphics and themes. The quantitative data aimed to achieve the first objective of the study which was to assess the nursing students' and the newly graduated professional nurses' understanding of the concept of human caring.

5.2 RESPONSE RATE

A total of 450 questionnaires were distributed. Out of the n=450 (100%) questionnaires distributed, only n=336 (75%) participants returned the questionnaires. Mailed and internet questionnaires typically achieve a response rate of less than 50% (Polit and Beck 2017: 275-276). Therefore, this response rate was considered acceptable for the study as a fair presentation of the sample.

5.3 SUMMARY OF METHODS OF DATA ANALYSIS EMPLOYED

Descriptive statistics including means and standard deviations where applicable were computed for the sample. Frequencies were represented in tables or graphs. Wilcoxon Signed Ranks test is a non-parametric statistical test for comparing two paired groups, based on the relative ranking of values between the pairs (Polit and Beck 2017: 748); used in this study, whether the average value significantly different from a value of 2.5 (5 central scores). This was applied to Likert scale questions. It was also used in the comparison of the distributions of the two variables. Kruskal Wallis Test: is a non-parametric test used to test the difference between three or more independent groups based on the ranked scores (Polit and Beck 2017: 733), it is

equivalent to ANOVA. A statistical procedure for testing mean differences among three or more groups by contrasting variability between groups to variability within groups, yielding an *F*-ratio statistic (Polit and Beck 2017: 719), was also used in this study. Mann Whitney U test: is a non-parametric equivalent test used to test the difference between the two independent samples t-test based on ranked scores was used (Polit and Beck 2017: 734). Pearson's / Spearman's correlation: Spearman's correlation measured how variables or rank orders were related. Pearson's correlation coefficient is a measure indicating the magnitude of a relationship between variables on the ordinal scale (Polit and Beck 2017: 745). The data from the quantitative data set was analysed in two forms. The first analysis included a composite analysis of the entire data set to assess how the two NEI's understudy performed and secondly comparisons were made of the three health facilities selected.

5.4 DEMOGRAPHIC PROFILE OF THE RESPONDENTS

Part A of the questionnaire enclosed interrogations that requisite respondents to specify the demographic information. The demographic info is presented below using the descriptive statistics. Figure 5.1 below presents the demographic info about race, religion, marital status and gender.

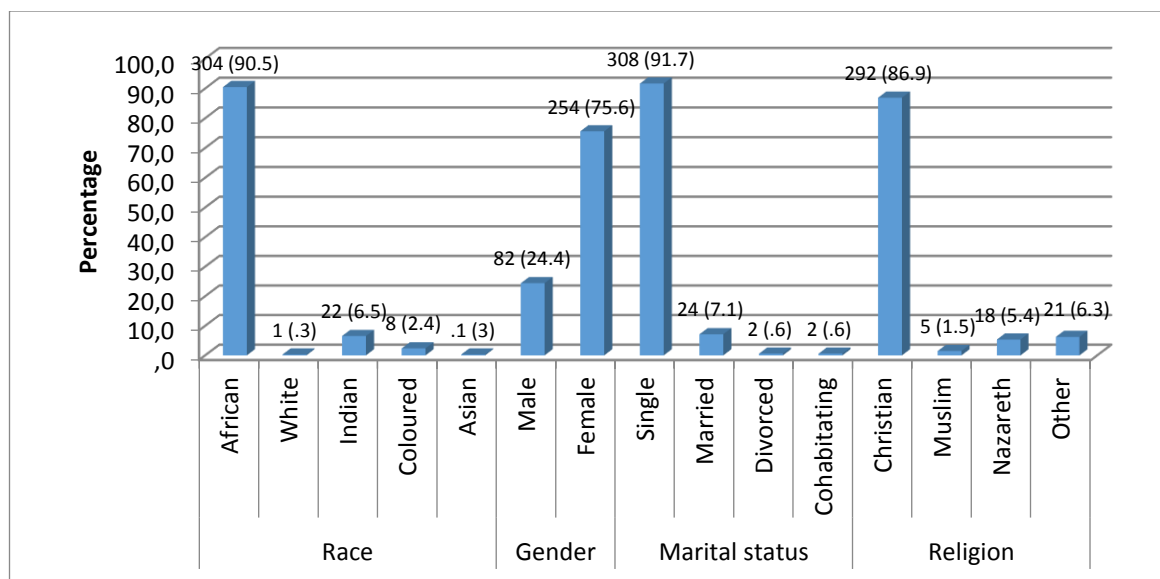


Figure 5.1: The demographic information association with regard to race, religion, marital status and gender

The above findings indicate that the majority of the respondents $n=304$ (90.5%) were African while only $n=22$ (6.5%) respondents were Indian, $n=8$ (2.4%) were Coloured, $n=1$ (0.3%) were White and only $n=1$ (0.3%) were Asian. On the 336 respondents 254 (75.6%) were females while 82 (24.4%) were males. Historically, the nursing profession was associated with females, but this study reveals that there is an increase in males who are currently joining the nursing profession. The above results show that approximately $n=308$ (91.7%) of the respondents were single, while $n=24$ (7.1%) of the respondents were married; $n=2$ (0.6%) were divorced while $n=2$ (0.6%) were cohabitating. The results indicate that the large number of the respondents has never married that is expected since in this study the nursing students and the professional nurses who are less than 5 years of experience were targeted. The above results show the majority of the respondents approximately $n=292$ (86.9%) of the respondents were Christians, while $n=18$ (5.4%) of the respondents were Nazareth; $n=5$ (1.5 %) were Muslim while $n=2$ (0.6%) were African religion, $n=3$ (0.9%) were Hindu, $n=1$ (0.3%) were Apostolic and $n=10$ (3%) did not specify their religion. In Table 5.1 below, age of the respondents are displayed.

Table 5.1: Age of the respondents

Age group in years	Frequency	Percent
18-19	15	4.5
20-29	284	85.8
30-39	31	9.3
40-49	1	.3
Missing	5	1.5
Total	336	100.0

The above findings indicated that the majority of the sample $n=284$ (85.8%) ranges between the ages of 20-29 years, while $n=15$ (4.5%) of the sample was between 18-19 years. The findings also highlighted that the older respondents between 40-49 years constituted only $n=1$ (0.3%) while those between 30-39 years formed only $n=31$ (9.3%). The results show that the sample was representative of both the youth and the small percentage of young adults though there was a low percentage of young adults between the ages of 30-49 years constituted about $n=32$ (9.6%). In Table 5.2 below, the professional status of the respondents is depicted.

Table 5.2: The professional status of the respondents

Professional status	Frequency	Percent
Nursing students	237	70.5
Community service nurses	41	12.2
Professional nurse	58	17.3
Total	336	100.0

Table 5.2 highlights that the majority of the respondents $n=237$ (70.5%) were nursing students. Of the total $n=58$ (17.3%) were professional nurses. Whilst, $n= 41$ (12.2%) of the respondents were community service nurses. In Table 5.3 below, years of experience of the respondents are depicted.

Table 5.3: Years of experience of the respondents

Years of experience of the respondents	Frequency	Percent
<1 year	46	13.7
2 years	117	34.8
3 years	80	23.8
4 years	90	26.8
5 years	2	.6
Missing	1	.3
Total	336	100.0

The results reveal that n=80 (23.8%) of the respondents were 3 years experienced in their current positions while about n=90 (26.8%) were 4 years experienced as professional nurses or nursing students and only n=1 (0.3%) was 5 years experienced as professional nurses. These findings confirmed that most participants were nursing students from their 2nd level of study or were five years or less experienced in their current positions as professional nurses. The results showed that approximately the majority of the respondents (34.8%) had about 2 years' experience in their current position as a nursing student or as professional nurses, while about 13.7% had less than a year of experience as professional nurses or community service nurses. In Table 5.4 below, the institution of study of the respondents is displayed.

Table 5.4: Institutions of study

Institutions of study	Frequency	Percent
UoT	159	47.3
Nursing College	175	52.1
Missing	2	.6
Total	336	100.0

Results in Table 5.4 indicate that n=159 (47.3%) of the respondents were studying or graduated from the selected University of Technology (UoT) while n=175 (52.1%) were studying or graduated from the selected College of Nursing and the n=2 (0.6%) did not indicate the institution from which they were studying or from which they graduated.

5.5 THE CARING BEHAVIOUR INVENTORY (CBI-42) DATA

Part B of the questionnaire contained questions from the CBI-42 with the four Likert scales. The Caring Behaviour Inventory (CBI-42) is a questionnaire with 42 items. The researcher received permission from the authors (Wolf, Giardino, Osborne and Ambrose 1994) to use this questionnaire in this study. The CBI-42 was initially established in the context of a caring model, principally the literature of Watson, 1979 in the late 1970s and (Watson 1988) 1980s and Gaut (1983). The CBI's theoretic delineation focused on the dimension of perception of nurse caring: Nurse compassion was distinct as a collaborative and inter-subjective progression that happens for the duration of collective susceptibility amongst the caregiver and the healthcare user, and that is mutually self and other focused. Caring is concentrating in the direction of the safety of the healthcare user, and occur when caregivers answer back to healthcare user in a compassionate state of affairs (Wolf *et al.* 1994: 107). This explanation was sustained by the frameworks of Gaut (1983) and Watson (1979). Table 5.5 presents the results of the Kaiser-Myer-Olkin (KMO) Measure of Sampling Adequacy and Bartlett's Test of Sphericity Approx. Chi-Square.

Table 5.5: KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.932
Bartlett's Test of Sphericity	Approx. Chi-Square	4183.037
	df	496
	Sig.	.000

The above results in Table 5.5 show that Kaiser-Meyer-Olkin (KMO) of .932 which indicated that the data was adequate for successful and reliable extraction. Bartlett's test $-p < .05$ indicated that correlations between items were not too low. The responses of each caring behaviour item were then ranked from the highest mean frequency to the lowest mean frequency. The highest mean responses rates were noted for the following ten responses:

- Giving the patient information so that he/ she can make a decision.
- Supporting the patient.
- Giving good physical care.
- Giving instructions or teaching the patients.
- Treating patient information confidentially.
- Making the patient physically or emotionally comfortable.
- Helping to reduce the patients' pain.
- Encouraging the patient to call if there are problems.
- Showing respect for the patient.
- Giving good physical care.

In Table 5.6, caring behaviour top 10 rank-ordered in the current study are explained.

Table 5.6: Caring behaviour top 10 ranks ordered

No	Item No	Individual item	Dimension of caring	Mean	SD
1	8	Showing respect for the patient.	Respectful deference	3.71	.593
2	28	Treating patient information confidentially.	Respectful deference	3.65	.595
3	7	Giving the patient information so that he/ she can make a decision.	Respectful deference	3.60	.600
4	38	Giving the patients' medication on time.	Respectful deference	3.59	2.311
5	41	Putting the patient first (patients are my priority).	Attentive to other's experience	3.55	.658
6	36	Helping to reduce the patients' pain.	Assurance of human presence	3.54	.617
7	18	Helping the patient.	Assurance of human presence	3.52	.628
8	35	Appreciating the patient as a human being.	Assurance of human presence	3.52	.618
9	9	Supporting the patient.	Respectful deference	3.52	.603
10	15	Making the patient physically or emotional comfortable.	Respectful deference	3.52	.623

Six of the top 10 items were incorporated into respectful deference; three were parts of the Assurance of human presence and one was incorporated into Attentiveness to others experience. The lowest mean responses rates were noted for the following 12 responses because the four of them were the same in terms of mean and could not be separated:

- Meeting the patients' stated and unstated needs
- Being patient or tireless with the patient
- Responding quickly to the patients' call
- Paying special attention to the patient
- Watching over the patient
- Returning to the patient voluntarily
- Managing equipment skilfully
- Being cheerful with the patient
- Helping the patient grow
- Spending time with the patient

- Touching the patient to communicate
- Trusting the patient

In Table 5.7 below, caring behaviour lowest of 12 ranks ordered in the current study are explained.

Table 5.7: Caring behaviour lowest 12 ranks ordered

No	Item No	Individual item	Dimension of caring	Mean	SD
1	33	Meeting the patients' stated and unstated needs.	Assurance of human presence	3.29	.682
1	17	Being patient or tireless with the patient.	Assurance of human presence	3.29	.683
1	34	Responding quickly to the patients' call.	Assurance of human presence	3.29	.697
1	39	Paying special attention to the patient.	Attentive to others' experience	3.29	.684
2	23	Watching over the patient.	Assurance of human presence	3.28	.651
3	30	Returning to the patient voluntarily.	Assurance of human presence	3.27	.713
4	24	Managing equipment skilfully.	Professional knowledge and skill	3.26	.688
5	25	Being cheerful with the patient.	Positive connectedness	3.23	.673
6	14	Helping the patient grow.	Positive connectedness	3.22	.660
7	4	Spending time with patient.	Positive connectedness	3.11	.747
8	5	Touching the patient to communicate.	Positive connectedness	3.01	.716
	1 2	Trusting the patient.	Positive connectedness	2 .9 3	. 7 9

The 12 of the lowest response rate were recorded as per: five of the lowest were incorporated into positive connectedness, another one was Professional knowledge and skill and five items were parts of the assurance of human presence, one item was attentive to others' experience. The Caring Behaviour Inventory was developed to measure caring by nurses. This tool assessed five dimensions of caring: respectful deference (12 items), professional knowledge and skill (5 items), assurance of human presence (11 items), positive connectedness (9 items) and attentiveness to others experience (3 items). The extraction method used in this study was principal axis factoring.

Rotation method used was Promax with Kaiser Normalization. Rotation converged in 6 iterations. In Table 5.8 below, the items included in the four dimensions of care were explained.

Table 5.8: Items included in the four dimensions of care

Construct	Items included	Alpha
F1 Assurance (ASS)	26-37	.899
F2 Respectful (RES)	1-3, 7-9, 11, 15	.842
F3 Connectedness (CON)	4,5,12,13,14,17,25,39	.805
F4 Knowledge and skills (KNO)	19, 20 ,22 ,24	.760

These four dimensions of care were then tested for reliability using the Cronbach's alpha. An alpha value >.7 indicated reliability. Single measures were formed for these four factors by averaging scores for the items in a factor. These composite measures were made up from ordinal variables, so they were treated as ordinal and so a Wilcoxon signed ranks test was applied to test for significant agreement/disagreement. All four constructs showed significant agreement. Friedman's test was done to see if any of the constructs is deemed more of a caring behaviour (higher agreement) than others. In Table 5.9, the descriptive statistics of the dimensions of caring was displayed.

Table 5.9: Descriptive statistics of the dimensions of caring

	ASS	RES	CON	KNO
N Valid	336	336	336	336
Missing	0	0	0	0
Mean	3.4396	3.5168	3.1744	3.3824
Median	3.5000	3.6250	3.1429	3.5000
Range	2.67	3.00	3.00	3.00
Minimum	1.33	1.00	1.00	1.00
Maximum	4.00	4.00	4.00	4.00

The researcher wanted to test for significant differences in these four factors scores across demographic variables. For those demographics with two categories, a Mann Whitney test was used; for those with >2 categories, a Kruskal Wallis test was used. With the age and years of experience, a Spearman's correlation was used. In Table 5.10 and Table 5.11 gender variables were displayed across the four factors.

Table 5.10: Gender variable ranks

	Gender	N	Mean rank	Sum of ranks
ASS	Male	82	153.49	12586.00
	Female	254	173.35	44030.00
	Total	336		
RES	Male	82	146.23	11991.00
	Female	254	175.69	44625.00
	Total	336		
CON	Male	82	169.10	13866.50
	Female	254	168.31	42749.50
	Total	336		
KNO	Male	82	158.92	13031.50
	Female	254	171.59	43584.50
	Total	336		

Table 5.11: Grouping Variable – Gender Test Statistics^a

	ASS	RES	CON	KNO
Mann-Whitney U	9183.000	8588.000	10364.500	9628.500
Wilcoxon W	12586.000	11991.000	42749.500	13031.500
Z	-1.613	-2.405	-.065	-1.042
Asymp. Sig. (2-tailed)	.107	.016	.948	.297

There is no significant difference across race and there is no significant difference across the marital status. Table 5.12 and in Table 5.13, religion variables are displayed across the four factors.

Table 5.12: Religion variable ranks

	Religion	N	Mean Rank
ASS	Christian	292	169.04
	Muslim	5	231.00
	Nazareth	18	134.64
	Other	21	175.07
	Total	336	
RES	Christian	292	173.85
	Muslim	5	190.90
	Nazareth	18	113.14
	Other	21	136.17
	Total	336	
CON	Christian	292	168.71
	Muslim	5	184.70
	Nazareth	18	138.08
	Other	21	187.74
	Total	336	
KNO	Christian	292	169.98
	Muslim	5	205.20
	Nazareth	18	160.28
	Other	21	146.19
	Total	336	

Table 5.13: Religion Test Statistics^{a,b}

	ASS	RES	CON	KNO
Chi-Square	4.383	9.460	2.749	2.077
df	3	3	3	3
Asymp. Sig.	.223	.024	.432	.556

In the religion variable, the Kruskal Wallis Test and Grouping Variable were displayed across the four factors. There was a significant difference in how people of different religions regard RES as caring behaviour, $\chi^2 (3) = 9.460$, $p=.024$. Christians regarded it as more of a caring behaviour than do Nazareth. There was no significant difference across the professional status. There was no significant difference across institutions as well. The correlation across the four factors was also tested as displayed in Table 5.14.

Table 5.14: The correlation across the four dimensions of care

			ASS	RES	CON	KNO
Spearman's rho	Age	Correlation	-.011	-.020	-.171**	.064
		Coefficient				
		Sig. (2-tailed)	.846	.712	.002	.244
		N	331	331	331	331
	Experience/Year study	of Correlation	-.031	.081	-.012	-.020
		Coefficient				
		Sig. (2-tailed)	.572	.137	.821	.714
		N	335	335	335	335

5.4 SUMMARY OF THE CHAPTER

This chapter provided a presentation of the quantitative data findings. The quantitative data showed that nursing students and newly graduated professional nurses had a clear idea regarding the constituents of caring in nursing. The findings identified a caring nurse as being giving the patient information so that he/ she can make a decision, supporting the patient, giving good physical care, giving instructions or teaching the patients, treating patient information confidentially, making the patient physically or emotional comfortable, helping to reduce the patients' pain, encouraging the patient to call if there are problems, showing respect for the patient and giving good physical care. In the next chapter, the qualitative results will be presented.

CHAPTER 6: QUALITATIVE RESULTS

6.1 INTRODUCTION

Chapter 5 of the study presented the results from the quantitative strand. This chapter provides a presentation of the qualitative data. The qualitative data is separated into two sections on the semi-structured interviews and the focus group discussions. The qualitative data aimed to achieve the first, second, third, fourth and fifth objective of the study which were to assess the nursing students', newly graduated professional nurses, nurse managers and nurse educators' understanding of the concept human caring, explore and describe the intrinsic and extrinsic factors related to the development of human caring attributes from the perspective of the nursing students, newly graduated professional nurses (less than five years of experience) and nurse educators, determine the nursing students' and newly graduated professional nurses (less than five years of experience) experiences in both the theory and the clinical setting that contributed to the development of human caring attributes according to their perspective, to explore and describe skills and abilities that are needed to be successful at caring from the perspectives of the participants and to determine the association between the working environment and the development of human caring attributes. The mixing of the two data sets will be done in the next chapter, showing the convergent nature of the mixed methods research design.

6.2 PARTICIPANTS' DEMOGRAPHIC DATA

The participants comprised nursing students from the four selected KZN CN campuses, nursing students from the selected UoT registered for a comprehensive four-year degree/diploma (R425), newly graduated professional nurses (less than five years of experience) from both the selected nursing college and UoT as well as nurse educators from both KZN CN and UoT and nurse managers from the three selected hospitals

where these nurses are working. The participant demographic profiles are presented in Table 6.1 below.

Table 6.1: Demographic characteristics of the study sample (n=76)

	DESIGNATION									GENDER		ETHNICITY			Total
	P N	STN	NL	SNL	OM	ANM	PRN CPL	CF	CSN	Male	Femal e	Africa n	Coloured	Indian	
KZNC N	5	4	12	11	-	-	1	4	2	4	38	30	7	6	38
KZN - HF	-	-	-	-	13	6	-	-	-	1	18	12	-	7	19
UoT	-	7	4	-	-	-	-	5	3	4	12	11	2	1	19
TOTAL	5	11	16	11	13	6	1	9	5	7	68	52	9	14	76

Key

KZNCN	College of Nursing
KZNHF	KZN Health Facilities
UoT	University of Technology
PN	Professional nurse
LN	Learner nurse
NE	Nurse educator
SNE	Senior nurse educator
ANM	Area nurse manager
PRNCPL	Campus Principal
CF	Clinical facilitators
CSN	Community service nurse

6.3 PRESENTATION OF FINDINGS

The presentation of findings that follows hereunder is provided following the themes in Table 6.2. The themes are presented in detail and supported by verbatim quotations from the participants. The verbatim quotations are italicised. The field notes are written in bold, bracketed and incorporated to add credibility to the findings. The abbreviations that are used to indicate verbatim quotations from a specific participant as follows in Table 6.2:

Table 6.2: Pseudo-codes for data differentiation

Institutions				
KZNCN	NC 1	NC 2	NC 3	NC 4
KZNDH	CF 1	CF 2	CF 3	
UoT	UT 1			
Type of interview:				
Focus group discussions	FG			
Semi-structured interviews	SSI			
Professional designation:				
Nurse educator	NE			
Nurse manager	NM			
Professional nurse	PN			
Learner nurse	LN			
Senior nurse educator	SNE			
Area nurse manager	ANM			
Campus Principal	PRNCPL			
Clinical facilitators	CF			
Community service nurse	CSN			

Thus, (NC1-NE: FG) refers Nursing campus 1, nurse educator in a focus group. Each theme, category was guided by the questions asked with the focus group discussions and the in-depth, semi-structured, interviews. Similar objectives guided the focus group discussions and the in-depth, semi-structured, interviews, hence the researcher decided to attach codes as mentioned above. These objectives were:

- What is your understanding of the concept human caring?
- Briefly describe the intrinsic and extrinsic factors related to the development of human caring attributes from your perspective.
- What are your experiences in both the theory and the clinical setting that contributes towards the development of human caring attributes according to your perspective?
- Briefly describe skills and abilities that are needed to be successful at caring from your perspectives.
- What is your opinion with regard to the working environment and the development of human caring attributes?

- What would you recommend as additional measures that can be put in place to assist and support nurse educators and nursing students engaging in nursing education and training to improve the quality of patient care?

The summary of the results is shown below in Table 6.3. Thus, (NC1-NE: FG) refers to Nursing campus 1, nurse educator in a focus group. Each theme, the category was guided by the questions asked with the focus group discussions and the in-depth, semi-structured, interviews. Similar objectives guided the focus group discussions and the in-depth, semi-structured, interviews, hence the researcher decided to attach codes as mentioned above. These objectives were:

- What is your understanding of the concept of human caring?
- Briefly describe the intrinsic and extrinsic factors related to the development of human caring attributes from your perspective.
- What are your experiences in both the theory and the clinical setting that contributes towards the development of human caring attributes according to your perspective?
- Briefly describe skills and abilities that are needed to be successful at caring from your perspectives.
- What is your opinion concerning the working environment and the development of human caring attributes?
- What would you recommend as additional measures that can be put in place to assist and support nurse educators and nursing students engaging in nursing education and training to improve the quality of patient care?

The summary of the results is shown below in Table 6.3.

Table 6.3: Themes and sub-themes that emerged from the interviews

Theme	Major themes	Sub-themes
1	Meaning of human caring.	1.1 Need for a person to be cared for. 1.2 Human caring as showing patient respect and dignity. 1.3 Human caring as being sympathetic and empathetic with the patient. 1.4 Human caring as a skill. 1.5 Human caring as helping. 1.6 Human caring as nurses showing care and concern for patients. 1.7 Human caring as the therapeutic use of self
2	Skills and abilities that are needed to be successful at caring.	2.1 Effective communication skills. 2.2 Professional competency: Knowledge about nursing procedures. 2.3 Triaging skills: clinical reasoning. 2.4 Emotional intelligence. 2.5 Respect for another human being
3	Factors related to the development of human caring attributes.	3.1 Intrinsic factors. 3.3.1 Primary socialisation. 3.2 Extrinsic factors. 3.2.1 Previous experience of the nurses as patients or patients' relatives. 3.2.2 Selection of nurses for training/ the reasons for joining the nursing profession. 3.2.3 Religious beliefs and cultural background of a nurse. 3.2.4 Inappropriate use of gadgets by nurses. 3.2.5 Peer pressure from other colleagues. 3.2.6 Impact of the rise in the number of social ills in our communities. 3.2.7 Lack of support mechanism from nursing management and NEIs management. 3.2.8 Role models' behaviour. 3.2.9 Gross shortage of human and material resources. 3.2.9 Negative attitudes towards nurses. 3.2.10 Negative publicity about the nursing profession. 3.2.11 Nurses' rights versus patients' rights
4	The experiences that contributed to the development of human caring attributes.	4.1 Theoretical experiences 4.2 The clinical setting experiences
5	Working environment and the development of human caring attributes.	5.1 Un-conducive work environment. 5.2 The hospital management issues. 5.3 Low staff morale.
6	Measures to be put in place to assist and support nurse educators and nursing students engaging in nursing education and training to improve the quality of patient care.	6.1 The revival of the hospital-based Clinical Teaching Department. 6.2 Counselling and emotional support for nurses'/ student nurses. 6.3 Confirmation or feedback. 6.4 Pre-exposure to the ward's situation for all the applicants.

6.4 MAJOR THEME 1: MEANING OF HUMAN CARING

The participants were asked about their understanding of the concept of human caring. The participants provided a description of their perception of human caring which included the meaning of human caring as a) need for a person to be cared for, b) human caring as showing the patient respect and the dignity, c) human caring as being sympathetic and empathetic with the patient, d) human caring as a skill, human caring as helping, e) human caring as nurses showing care and concern for patients and f) human caring as the therapeutic use of self.

6.4.1 Need for a person to be cared for

Most participants in the current study perceived human caring as meeting patients' needs. The following statements reflect learner nurses' perceptions of caring:

"It involves a nurse going above and beyond the call of duty, doing things for another person, worrying about them, showing them compassion in their time of need" (NC 3-LN: SSI)

"It encompasses the quality of a nurse putting patient's needs before hers." (NC 1-LN: SSI)

"It means nurses giving patients the basic essential care" (NC 4-LN: SSI)

The following statements reflect nurse educators' and nurse managers' perceptions of human caring as meeting the patients' needs:

"Human caring is about individuals, it's about families, it's about community and the public at large coming to us as nurses with specific needs" (CF 1-NM: FG)

“When you are caring, it is important to identify the need for that care.” (UoT 1-NE: FG)

6.4.2 Human caring as showing the patient respect and dignity

The participants in the current study perceived human caring as showing patient respect and dignity. The following statements reflect learner nurses' perceptions of caring as showing respect and dignity:

“Human caring is treating the patient with respect and dignity.” (NC 1-LN: SSI)

“It’s just about being human and treating another human being in a dignified manner,” (UoT 1-LN: SSI)

Nurse educators and nurse managers' shared sentiments with learner nurses and said:

“Human caring is viewed as human interaction in respect full manner.” (FC2-OM: FG)

“Human caring is focusing on caring for individuals and looking at individuals as human beings. So it is different from caring for animals.” (NC2-NE: FG).

6.4.3 Human caring as being sympathetic and empathetic with the patient

The majority of the participants perceived human caring as being sympathetic and being empathetic with the patient. Presented below are the supportive quotations by the nursing students:

“Human caring is focusing on caring for individuals, and looking at individuals as human beings.” (NC2-LN: SSI)

"I also think is that as human if you are a person who is going to care for another human you must also imagine yourself being that particular individual which is in need" (UoT-LN: SSI)

"People like me who have a conscience. I empathise with another human being, so, I make sure that the care I render to my patient is always relevant; because I just imagine myself as that patient." (NC 3-LN: SSI)

"When you see that a person does not have a visitor you go and sit with them and make a conversation with them. If you see that your patient is depressed, you go and speak to them and ask them what is going on and find out what you can do for them" (NC1-LN: SSI)

Nurse educators and nurse managers supported the views of nurse learners and said:

"For me, human caring means to be sympathetic and empathetic, and being able to identify when to be sympathetic and when to be empathetic." (NC 2-NE: FG)

"To show empathy and to be sympathetic towards people you care for"(NC 3-NE: FG)

6.4.4 Human caring as a skill, human caring as helping

The participants in the current study perceived caring as providing help to another human being in a skilful manner. Nursing students described human caring as:

"Those patients who cannot feed themselves, we as nursing students and permanent staff as well we help them with their meals" (NC 3-LN: SSI)

"I think human caring is like a skill; and like the skill that will carry throughout your life, you have to have it throughout your career. (NC 1-LN: SSI)

Nurse educators and nurse managers supported the views of nurse learners and said:

"The concern must be expressed in doing the right thing for the patient." (NC 1-NE: FG)

"I think, it stems from the right attitude, and it ends up as action. You can't say I care without the actions." (CF 1-NM: FG)

"Human caring is assisting someone unable to for themselves what you would like to do for yourself. So in that way, your humanness comes out in caring for the person." (CF 3-NM: FG)

6.4.5 Human caring as nurses showing care and concern for patients

The majority of participants perceived human caring as nurses showing care and concern for patients. The following are the supportive quotations by the nursing students:

"To show compassion for the patient" (NC 2-LN: SSI)

"It means taking care of the person physically and psychological aspect" (NC 1-LN: SSI)

"It means taking care of a human being holistically." (NC 3-LN: SSI)

Nurse educators and nurse managers supported the views of nurse learners in this regard and said:

"I can't come up with my mouth and say oh shame oh shame when there is nothing in my fingertips." (NC 1- NE: FG)

"When you care you are giving the best and the honest kind of care that you are supposed to give to the other person." (CF 1-NM: FG)

"When you are caring you need to be compassionate to love what you are doing and be responsible for that particular person you are caring for." (UoT 1-NE: FG)

6.4.6 Human caring as the therapeutic use of self

The participants in the study perceived human caring as the therapeutic use of self. Nursing students described human caring as:

"The patient should feel that there comes our nurse and because of the nurse wearing a smile because of the nurse showing love to her profession showing the love of work, showing all those things that a patient would like."(NC 3-LN: SSI)

"For me, it means that a nurses' appearance to the patient/client that she is caring should be a therapy." (UoT 1-LN: SSI)

The following statements reflect nurse educators' and nurse managers' perceptions of caring as the therapeutic use of self:

"In caring for a human being, it's very important that a person should use herself as a therapy to another human being." (NC 4- NE: FG)

"In other words, it's not about the nurse relying on the medication that you give to patients, as a person who is caring for a patient but also uses yourself as, a person uses herself" (CF 3-OM: FG)

6.5 MAJOR THEME 2: THE SKILLS AND ABILITIES ARE ASSOCIATED WITH THE HUMAN CARING ATTRIBUTE

The participants were asked to briefly describe skills and abilities that are needed to be successful at caring from their perspectives, and the findings were that the skills and abilities that are associated with the human caring attribute are (a) effective communication skills and good interpersonal relationship, (b) professional competency: Knowledge about nursing procedures, (c) triaging skills: clinical reasoning, (d) emotional intelligence and (e) respect for human dignity. A description of these perceptions follows hereunder.

6.5.1 Effective communication skills and good interpersonal relationship

All the participants stated that effective communication skills and good interpersonal relations are important for all the nurses to have to facilitate their interaction with patients, community, and the members of the multi-disciplinary team. This is reflected in the following learner nurses' statements:

Nurses need to have a positive attitude, in the sense that you need to be an approachable person” (NC 1-LN: SSI)

“At some stage, you will find nurses wheeling patients to the theatre when the patient was not even told about what procedure is going to be done.” (NC 4-LN: SSI)

“You need to have good listening skills because when you do not have good listening skills you are not going to pick up everything about that particular patient” (NC 2-LN: SSI)

Nurse educators and nurse managers shared sentiments with nursing students. They said:

“These days our nursing students work as mechanics that are working on the car ‘you take off a faulty part and replace it with a working one’ without communicating anything to the car.” (NC 4-SNE: FG)

“We need to remind our students to be more expressive nurses than to be instrumental nurses.” (UoT 1-NM: FG)

6.5.2 Professional competency: Knowledge about nursing procedures

All the participants in this study stated that nurses are supposed to be knowledgeable about the nursing procedures/ skills and continuously update themselves regarding the new developments in their field for them to render quality patient care. These realities were appropriately captured in these excerpts by the nursing students below:

“I think it is real world versus fantasy world. What we are being taught is just unrealistic that does not exist in reality.” (NC 3-LN: SSI)

“As we do accompaniment in the ward, we find our students doing skills the wrong way and when we ask them why are you doing this procedure like this? They will say resources are not available and you find that the permanent staffs in the ward always say you are going to get tired my dear, we all started like that” (NC 2-CF: FG)

“I saw the needles were punctured into different vials like that and then they will just open the syringe and withdraw and put into the IV solution mini bags.” (NC 4-SNE: FG)

“Sometimes students will verbalise that what they are teaching us at college is not what is happening in the wards.” (NC 3-CF: FG)

“Professional norms and values you need to uphold the very high as a healthcare professional.” (UT 1-NE: FG)

“Academic skill also is very important they need to keep abreast of changes in their field and be knowledgeable about trends and read the journals.” (UoT 1-CF: FG)

6.5.3 Triage skills: clinical reasoning

The participants stated that for nurses to do their work effectively they need to have the triaging skills-clinical reasoning. The nursing students articulated their viewpoints as per their perceptions and expressed the following sentiments about the triaging skills of a nurse as stated in the following excerpts:

“It also becomes the internal conflict now you have to start choosing and you know we are supposed to be given equal nursing care to everyone but we end up creating our own internal “triage system” (NC 1-LN: SSI)

Nurse educators and nurse managers also stated that clinical reasoning is a prerequisite for all nurses to be successful in rendering care.

“The triaging skill or ability will keep you going irrespective of the type of the ward you are working in.” (NC 4-SNE: FG)

“You do not care whether this patient needs one tablet for pain when there is this other patient who needs something more important.” (CF 3-NM: FG)

“There is no time to spend with patients because you cannot even stand and feed the helpless patient.” (CF 1-NM: FG)

6.5.4 Emotional intelligence

Emotional intelligence is the desired pre-requisite for the successful rendering of quality patient care. This is indicated in the following statements by learner nurses and community service nurses:

"I think that nurses must have enough emotions to understand the patient in every aspect because it is not every patient that is easy to deal with." (NC 1-LN: SSI)

"Even if they call you ten times but I will tell them humbly and show them care when I address my patient." (UoT 1-CSN: SSI)

"Even when I am in the ward during the visiting hour's families will come from all sites and every site but is how professional the nurse carries herself or himself that matters." (NC 1-CSN: SS1)

"I think we (nurses) have a problem balancing how much emotion do we need to vest in a patient?" (NC 3-LN: SSI)

Nurse educators and the clinical facilitators also shared sentiments with learner nurses and community service nurses and said:

"If the nursing students can learn to talk, not that freedom of speech which is aimless but expressing yourself, your feelings. Without hurting the next person and they learn that very late in training." (NC 2-CF: FG)

"So, we (nurse educators) when we are assessing nursing students we want to check if they have mastered those attributes such as acceptance, kindness the affective, psychomotor and cognitive skills." (NC 1-NE: FG)

6.5.5 Respect for human dignity

According to all the participants in this study nurses need to be humane to care for another human being, they need to possess some certain attributes which are respecting and treating other human beings with dignity. These realities by the nursing students and the newly graduated professional nurses were appropriately captured in these excerpts below:

“Respect is the most paramount skill because in nursing you need to have respect.” (UoT 1-PN: SSI)

“To care for a human being calls for certain attributes from you as a caregiver, like showing respect for and treating the other person with dignity.” (NC 1: LN: SSI)

Nurse educators and the clinical facilitators also shared sentiments with learner nurses and said:

“Your values, your morals, you know things that are basic like “Ubuntu” (humanity) and that feeling that “you are a person because of another person”. (NC 1: NE: FG)

“Nurses need to treat patients with respect and dignity” (FC 1: OM: FG)

6.6 MAJOR THEME 3: THE FACTORS RELATED TO THE DEVELOPMENT OF HUMAN CARING ATTRIBUTES

The participants were asked to briefly describe the intrinsic and extrinsic factors related to the development of the human caring attributes from their perspective. The findings were that the intrinsic factor that plays a major role is: a) primary socialisation whilst for the extrinsic factors the following factors were identified: a) personal experience of the nurses as patients or patients’ relatives, b) religious beliefs and cultural background of a nurse, c) inappropriate use of gadgets by nurses, d) peer pressure from other colleagues, e) impact of the rise in the number of social ills in our communities, f) inadequate selection process / wrong career choice, g) lack of support mechanism from nursing management and NEIs management, h) role models’ behaviour, i) nurse educators with a negative attitude towards nursing, j) role of the professional nurses and operational managers in student teaching, k) theory-practice gap, l) emotional support for nurses/ student nurses in dealing with negative patient outcomes, m) inadequate involvement

of the multi-disciplinary team in nursing students support and guidance, n) image of nurses as perceived by the media and the public and o) nurses' rights versus patients' rights. A narrative of these opinions follows hereunder.

6.6.1 Intrinsic factors

6.6.1.1 Primary socialisation

All the participants in the study cited that that nurses come to nursing with certain attributes from primary socialisation especially from: family members, religious and cultural background. Primary socialisation plays a major role in how nurses interact or relate to other human beings. These views were reflected in the following statements by the learner nurses and newly graduated professional nurses:

"If that nurse was brought up in a very loving caring environment where the family care for each other and loved each other. So, if they come from a loving caring background they will project love and care towards patients."(NC 3-LN: SSI)

"Nurses come to nursing with certain attributes from their families, from values as well, from being in contact with certain groups of people like church, like doctors that we work with." (CF 1-PN: SSI)

"The upbringing and the type of people that you associate with has a big impact on the person that you become in the future and the sort of nurse that you become so basically."(CF 3-PN: SSI)

Whilst nurse managers and nurse educators asserted and said:

"Some students even if they are socialised in a certain manner but they do deviate and do whatever is not according to the norms and the vision, the mission of their parents." (NC 4-SNE: FG)

“All primary socialisation at home and professional socialisation they still deviate like there are ethos and caring and also ethos and professional practice they are taught how to communicate with people but beyond that, they still do things that are not acceptable.” (CF 2-NM: FG)

6.6.2 Extrinsic factors

6.6.2.1 The personal experience of the nurses as patients or patients’ relatives

The participants reported that the previous personal experience of the nurses as patients or patients’ relatives can shape their caring abilities in a certain way. These realities by nursing students and community nurse service were appropriately captured in the following statements below:

“I think sometimes even the personal experiences like for instance may be in your family there is this somebody who is sick and you have witnessed the way she or she was cared, that I can do that too.” (UoT 1-LN: SSI)

“If whilst you were a patient yourself, you were not feeling okay about that then definitely you will have to practice what you wanted to be done to you.” (CF 2-CSN: SSI)

“In a nutshell, I would say “even bad experiences do bring the positive outcomes.” (NC 2-LN: SSI)

“There was a nursing student who hated to work in a paediatric ward, she then disclosed to me that at the age of fourteen years she fell pregnant and was forced by parents to do the illegal abortion and the gestational age was about six months. So, unfortunately, for her, that foetus was fully developed and alive during termination. So, that mental picture is still haunting her.” (NC 4-CF: FG)

"I think one's experience of being a patient herself, in some other people though; will improve their caring aspects as nurses." (UoT1-NE: FG)

"Nowadays nursing has gone down the drain and I don't know how we can pick it up really" (NC 3-NE: FG)

"We even use those very bad incidences in class as examples, to avoid recurrences." (NC 2-CF: FG)

6.6.2.2 Religious beliefs and cultural background of a nurse

All the participants cited that the religious beliefs and cultural background of a nurse also plays a major role in how nurses execute their human caring duties. Some participants stated how their religion commanded them to take good care of each other especially the sick and the poor. These realities by nurse learners were appropriately captured in the following excerpts below:

"God says we must take care of each other especially the weak and the poor" Others because of their beliefs end up dropping out because you find that their beliefs do not tally with some nursing practices. For instance, with the cultural beliefs sometimes you are not allowed to bath a male patient." (NC 1-LN: SSI)

"Doing bad things to others are associated with hell, so I do not want to go to hell, because of the bad things I did to human beings. I do believe that all human beings are the same irrespective of gender race or social standing." (NC4-LN: SSI)

Nurse educators shared sentiments with the nursing students in this regard and said:

"I encountered in the midwifery section, with male students it becomes very difficult for them to come into terms with observing deliveries before they can deliver any babies." (NC 4-CF: FG)

6.6.2.3 Inappropriate use of gadgets by nurses

Some participants shared their opinions on how nurses were using their gadgets whilst on duty. These realities by nurse learners were appropriately captured in the following excerpts below:

“They (nurses) don’t have time for caring, because they are busy with their phones.”(NC 4-LN: SSI)

Nurse educators also shared their opinions and said:

“Listening to their conversation on phones so the time the environment because if they are allowed to use phones on duty then the caring suffers.”
(NC 4-SNE: FG)

6.6.2.4 The peer pressure from other colleagues

The participants cited their opinion that peer teaching also plays a significant role in mentoring and supporting the nurse in training. These realities by nurse learners and newly graduated professional nurses were appropriately captured in the following excerpts below:

“Peer pressure comes in because now if you are going to be caring and kind, you are not cool.” (NC 4-LN: SSI)

“Peer pressure could be the external factor when your colleagues do not like to be in the ward, taking care of the sick person. They would like to take short cuts or take long hours of lunch and long hours of tea breaks” (FC 1-PN: SSI)

“You (the parents) teach the children to be kind to each other and then you hear they are fighting at schools and then you realise there is something because now that peer pressure is like it’s forcing them to now acting and to behave in a different way towards what they have been taught at home.” (NC 4-SNE: FG)

6.6.2.5 Impact of the rise in the number of social ills in our communities

The participants articulated that the rise in the number of social ills, so according to them our recruits are going to behave likewise because that is the only thing they understand. These realities by the learner nurses were appropriately captured in the following statements below:

“If you look at society, our society is not what we may consider as normal as an individual. So, in those circumstances who teaches these people something called obedience, something called respect?” (NC 3-LN: SSI)

The nurse educators shared sentiments with the nurse learners and said:

“These young stars you teach them something but they just go against that, they don’t listen.” (NC 2-CF: FG)

“We also don’t have time for our children. Ehh, as much as we can say our children have got a mother and a father. There is no time. We don’t have time for them and if we get home we are busy.” (NC 4-NE: FG)

“The little time you spend with your child communicates properly, look into their eyes and see this child doesn’t look okay. Hug them, praise them.” (NC 3-NE: FG)

6.6.2.6 Inadequate selection process / wrong career choice

All the participants raised their concerns about the way recruitments and the selection for training was conducted for nurses are conducted nowadays. These realities by the nursing students were appropriately captured in the following statements below:

“So, in the class, it’s about only two people who are willing or loving the profession” (NC 2-LN: SSI)

"I think there is something wrong about the way that selections are conducted for nursing training." (CF2-PN: SSI)

Nurse Managers and nurse educators shared their concerns regarding career choice and the recruitment process and said:

"Because applications are electronically selected online or it is done by Head office with no interviews, to access the personality because marks grades can show something else that does not match the personality" (CF 2-NM: FG)

"This decrease in the number of student nurses also does have a negative impact at the operational level." (CF 3-NM: FG)

"They come into nursing knowing that it's all about giving medication and then others they think that if you are not afraid of blood it means you can be a nurse." (CF 1-NM: FG)

"Nurses have to love what they are doing. You need to have compassion. What I have discovered when I was asking my students why they are doing nursing, majority of them said they don't like nursing."(NC4-CF: FG)

"Another thing is the subject which is Ethos of Nursing and the Professional Practice once they enter and they are shaped to this subject and they are groomed along. They end up loving nursing."(NC 2-SNE: FG)

"Some students will verbalise that you know what I do not like nursing, but I was forced by circumstances to end up coming here. I completed my degree in other institutions; it's just that I did not get a job, so I ended up joining nursing."(UoT 1-CF: FG)

6.6.2.7 Lack of support mechanism from nursing management and NEIs management

All participants cited that nursing students and qualified nurses, including nurse managers and nurse educators find it easier, to care for the patients when their superiors show them that they also care for them. These views were reflected in the following statements by the nurse learners:

"I had a smash and grab recently. So, I tried just to hide my emotions, I had to act as nothing happened. I phoned one of my lecturers and told her what happened and I burst into tears because I felt like I have a shoulder to cry on. I felt like my mother was being there." (NC 1-LN: SSI)

The nurse educators shared their concerns regarding the uncaring attitudes displayed by superiors towards the junior nurses regardless of their professional rank and said:

"We are speaking totality in caring but when it comes to nursing students neglect the mental aspects of our students."(NC 3-NE: FG)

"We (nurse educators) are so focused on competency that is only competency-based accompaniment then we disregard this other side, are you coping?" (NC 3-NE: FG)

"Sometimes our (nurse educators) rules are so rigid in such a way that we disregard the caring part for our students" (NC 2-NE: FG)

"Nursing is cruel, I'm sorry to say that I'm a nurse and I love being a nurse. It's impossible to say to a person, you leave your problems at the gate and come into work. I am a total human being, if I am not alright mentally how am I going to care?" (NC 3CF: FG)

6.6.2.8 Role models' behaviour

The participants reported that for nurse learners to adopt good caring behaviour and attitudes, they need to have seen someone they admire doing it. The following are their sentiments about the role modelling of nursing care as stated in the following excerpts:

"The role models that we saw in the clinical areas were our pre-setters and seniors their behaviour and interactions with patients and we looked at them and admired them" (NC 4-LN: SSI)

"Whenever we (nursing students) try to do the nursing procedures the correct way in the wards we get discouraged by the permanent nursing staff. They say, 'Relax, you will also get tired – we were also like you when we joined nursing.'" (UoT- LN: SSI)

"If the person was educated or trained properly in nursing, and when it came to practice had gotten good role models, which are displaying the character of caring, then that person will display good caring." (CF 2-PN: SSI)

The nurse managers and nurse educators shared sentiments with nurse learners and said:

"I believe students model my behaviour and I believe in treating students nicely." (UoT 1-CF: FG)

"When the student goes to the clinical area and finds that is it is different – the attitudes are negative, the practice is not according to principles and guidelines of the procedures – and then the person loses the whole primary socialisation and end up practising what is done in the ward." (UoT 1-CF: NE)

"I'm around 25 years in the profession, but I still remember my lecturers in class. And I still remember my role models in the clinical area." (NC 2-SNE: FG)

"I have observed that sometimes some lecturers can instil that negativity about the nursing profession into the minds of the learner." (NC 4-NE: FG)

"I think our role models; I'm still going to use the term role models, our preceptors, created a very positive experience for us. I think today our students are not getting that." (NC 3-NE: FG)

"At the college, we stress the importance of professional image to our students but now in the clinical area you find some professional people dressed anyhow and you wonder what our students are learning from such people." (NC 1-CF: FG)

6.6.2.9 Nurse educators with a negative attitude towards nursing

The participants also articulated that nurse educator who had experienced negativism during the training where their lecturers or senior nurses had been implanting to them that they are nothing they are going to fail and all those negative things you will find that they transfer that negative attitudes to the neophytes. These realities were appropriately captured in the following statements below:

"Some of the lectures had difficulties during training that is why they make it hard for us as well." (NC 2-LN: SSI)

The nurse educators also stated that there are nurse educators with a negative attitude towards the nursing profession and said:

"It all started from the time when the lecturer was also training to become a nurse." (NC 4-CF: FG)

“Sometimes you will find that a person who is a lecturer has experienced negativism during the training where you find a senior nurse have been implanting to her or him during the training that you are nothing” (NC 1-PRNCPL: FG)

6.6.2.10 Role of professional nurses and operational managers in student teaching

The participants cited their concerns regarding the reluctance of professional nurses to assume their role in teaching and guiding nurse learners in the clinical area. These realities by the nurse learners were appropriately captured in the following statements below:

“When it comes to the ward sometimes we have rushed along when we are doing procedures.” (NC 1-LN: SSI)

“The different personalities in a working environment sometimes do negatively influence us.” (NC 3-LN: SSI)

Nurse educators also raised their concerns regarding the reluctance of the professional nurses in the wards to mentor and guide nurse learners in the clinical area and said:

“You find that sometimes when we (nurse educators) apply the disciplinary measures to our students as college, we experience resistance from some operational managers.” (NC 4-NE: FG)

“In the working place, it is a war zone. The situation in the workplace is very bad. As a nursing student, I can see that this professional nurse does not get along with that professional nurse. I am not sure what causes nurses to bad-mouthing each other to patients.” (NC 1-LN: SSI)

"It is not only the neophytes who display the bad attitude in nursing sometimes the professional nurses do display that "I do not care attitude."(NC 2-NE: FG)

"Another thing is that some nurses come here having the passion to nurse patients, we prepare them emotionally and otherwise how to nurse patients but due to negative attitudes from other professional nurses they end up adopting them." (UoT 1-CF: FG)

"The attitude of the professional nurses in the ward is very bad or they even tell the students that do not tell us about your lecturers they do not know anything except what is written in the book." (UoT 1-NE: FG)

"The operational managers need to know the scope of practice and the level of training of the students in the ward." (UoT 1-CF: FG)

"But it becomes very hard for the students because some of the students copy bad attitudes from those professional nurses." (NC 4-CF: FG)

"I think some other things that can contribute to that misbehaviours substance abuse, especially alcohol and drugs." (NC 4-SNE: FG)

"Professional nurses in the wards must remember their four-folds teaching role. They are supposed to teach their staff and patients as well." (NC 1-CF: FG)

6.6.2.11 Theory-practice gap

Participants argued that they were sent to the ward to do a specific part of their training outcomes because when they come to campus they were taught specific part of theory; then they were expected to practise that in the wards, but they do not get time to do that in the wards, because nursing students are

now regarded as part of the workforce. These realities by nurse learners were appropriately captured in the following statements below:

“The way we are taught how to do activities at college is not the same way we do them in the ward because of a shortage of staff and certain things are out of stock for example sometimes you try to provide the patient with privacy there is no screen in the ward.” (UoT 1-LN: SSI)

Caring depends on the working environment you are in. If certain things are not available to you that is the most frustrating.” (NC 1-LN: SSI)

“I think human caring is decreasing as it is badly affected because it is not the nurses’ fault but the thing is there is a shortage of staff. If there is no staff you cannot expect three nurses to care for 40 patients.” (NC 1-LN: SSI)

“They (authorities) forget that as student nurses we do not go there to compensate for the shortage of staff, we go there to learn.” (NC 3-LN: SSI)

“Eish! In one situation, we ended up using the unsterile daily towels that are used to bath patients for wound dressing, so we forget about sterility. We just pour wound cleaning solutions on daily towels and clean the wound.” (NC 1-LN: SSI)

“I had one experience in maternity ward not too long ago; this patient was sent for a caesarean section so I was taken from labour ward because there was nobody else to accompany that patient as a midwife. So I had to go with the patient and the patient said to me the doctor did not speak to her to say you know you are going for a caesarean section because of this and that.” (NC 2-LN: SSI)

The nurse educators in this study also shared sentiments with their students regarding the abuse of nursing learners in the clinical area due to the shortage of human resources, which end up being students' burden according to them and they said:

"When there is a procedure to be done the patient is just told ok 'you are going for the CT scan' and he or she is not told what is it for and why is it done."(NC 2-CF: FG)

"The students when they are giving medicine they must lock the medicine trolley, where are they going to getting the padlocks? I encourage them to buy it for themselves for their good when they are doing that procedure. Yesterday I was assessing the learner; the dressing pack was incomplete." (NC 1-CF: FG)

"You wonder actually if the poor patients are even getting the care that they should be getting. You wonder if these nurses on training, what they are learning." (NC 1-NE: FG)

6.6.2.12 Emotional support for nurses'/ student nurses in dealing with negative patient outcomes

The participants cited that the nursing students are faced with the challenge of the shortage of staff and equipment, dealing with the negative patient outcome as a result of the un-conducive working conditions, adds another emotional strain on the nurses on training according to them. These realities by nurse learners were appropriately captured in the following statements below:

"I had an experience 12 months ago if I am not mistaken we admitted a patient for medication overdose, he was 17 years old very young. He was brought in by his father just during report taking from the staff, he crushed, and we left everything and started active resuscitation. There was a certain

drug that was ordered as an antidote to reverse paracetamol overdose. We ran to around in different directions, we ended up losing those young gentlemen, whereas if the antidote was readily available, and where it was meant to be, that patient would have survived (she is so emotional almost in tears).” (NC 1-LN: SSI)

“The doctor on call said I must get the patient up and do chest compressions, because we had resuscitation that day, so when we lost that patient. I felt devastated I broke down” (CF1-CSN: SSI)

“I wish I can clone myself so that I can do more work because you have a situation where you want to do everything but you cannot. It is a very difficult situation and I wish the public can see things through our eyes.” (NC 3-LN: SSI)

“Also in care in the ICU, maybe let us say in trauma doing resuscitation, everybody wants to save life, you will be doing everything, and then you lose a life. I’m sure debriefing at that stage will be necessary.” (CF 1-PN: SSI)

The nurse educators and nurse managers shared sentiments with the newly graduated nurse educators and said:

“Bedside the shortage of human resources in the wards, there is a shortage of material resources; we teach students how to prevent cross-infection here at the college and everything else. Then in the ward, the students are asked by staff to tell the patients to bring a blanket from home” (NC 1-CF: FG)

“Even the employees themselves are stealing from the public institutions.” (NC 4-SNE: FG)

“I would take for instance nurses who are dealing with rape victims that have a negative impact on the nurses’ psychological well-being.” (NC 3-NE: FG)

"It is important for nurses to get that support from our seniors, especially under the prevailing working conditions" (CF 3-OM: FG)

"Infrastructure is also a challenge because we do not have enough side wards so like we have only three side wards in the ward. There is no time to clean and fumigate the sideward before admitting the next patient in that ward and then we are transferring infection from one patient to another. We are not sure whether there is just TB, MDR or XDR. It is just TB up until we have results. It will be better if we have enough." (CF 1: NM: FG)

"In another tertiary hospital in KZN, after resuscitation, there was a certain Professor who was very particular about that, and he used to make sure that after resuscitation people who were involved in this resuscitation they should come for debriefing." (NC 2-CF: FG)

"We need the mentorship programme that we don't have if we have the mentorship programme that's where the nurses get their support." (CF 2-NM: FG)

"There is a need for staff support I mean enough staff support. At least just to know that your supervisor's got your back." (CF 2-OM: FG)

"We as lecturers we need to be available for our students." (UoT 1-NE: FG)

6.6.2.13 Inadequate involvement of the multi-disciplinary team in nursing students support and guidance

The participants cited that they were not taught during the ward rounds in the clinical learning area as they would like it to be. The following are the caption of the statements by the learner nurses:

"We, students I think they need to teach us when they are doing ward rounds or medication they should call the students. We are deprived of learning moment." (UT 1-LN: SSI)

The nurse educators shared sentiments with nurse learners in this regard and said:

"In one of our stakeholders' meetings here at college, we even questioned the way doctor's rounds are conducted these days. You know doctors most of the time do their rounds because there is no one to go with the doctors." (NC 4-SNE: FG)

6.6.2.14 Image of nurses as perceived by the media and the public

The participants believed that media should get both sides of the story right before going public about any negative incidences. These realities by the nursing students were appropriately captured in the following statements below:

"Nurses' image will always be tarnished in the media's eyes." (NC 2-LN: SSI)

"It is a very difficult situation and I wish the public can see things through our eyes." (CF 1-PN: SSI)

"Recently, on media, I have been seeing a lot of negative perception about nursing and also that breaks you down as a person because you do your best in the clinical area but there is only certain amount of allocated duties that you can do on that particular time." (NC 1-LN: SSI)

"When you are a nurse you need to be willing to forgive a lot because sometimes when relatives have a family member who is approaching death they turn to take out their frustration on you as a nurse." (UoT 1-LN: SSI)

"In the patients' perspectives they feel like we are not caring enough but it is because they do not know what is going on because we do not tell them, we cannot tell them." (CF-PN: SSI)

The nurse managers shared sentiments with nurse learners in this regard and this is noted in the excerpts below:

"You find five nurses to fifty patients. One cannot deliver proper care in that nurse patients' ratio." (CF1-NM: FG)

"You see like in the media now we are having bad coverage, but there is another side to that story, which will never reach the media." (CF2-NM: FG)

6.6.2.15 Nurses' rights versus patients' rights

The participants in this study revealed that nurses were concerned about the government who is paying more attention to patients' rights versus healthcare workers' rights. Surprisingly, the nurse managers in the current study also raised their concerns about how the nurses over-emphasised their rights over patients' rights. The nursing students and nurse educators did not share their opinions in that regard. The nurse managers from all the three health facilities shared their views as noted below:

"Many of the times you hear emphasis being put on patients' rights but you hardly hear about healthcare workers' rights." (CF 3-NM: FG)

"We have serious issues as managers as far as rights are concerned, we cannot apply or implement disciplinary action because we are scared of unions or our tyres being slashed." (CF 2- NM: FG)

6.7 MAJOR THEME 4: THE EXPERIENCES THAT CONTRIBUTED TOWARDS THE DEVELOPMENT OF HUMAN CARING ATTRIBUTES

The participants were asked to relate their theoretical and clinical experiences that resulted in the development of the human caring attributes in their perspectives. The findings were that, a) theoretical learning experiences and b) the clinical learning experiences. The description of these perceptions follows hereunder:

6.7.1 Theoretical experiences

The participants cited that theory exposure resulted in gaining the understanding of cultural diversity and the importance of caring in the nursing profession. The following are the caption of the statements by the learner nurses:

“Social Science component really opened my eyes on cultural beliefs. So that cultural understanding makes me care for the patients better because I understand where they come from.” (NC 1-LN: SSI)

“As for lecturers, they teach us so many things. They taught us about holistic nursing care and also to treat our patients equally irrespective of their race, colour, creed or social standing. They also taught us that we should not allow what is happening in the clinical setting to change us what we are taught in college.” (UoT1-LN: SSI)

“I have learnt to be patient and understanding the people and to understand that the way I will take and react to something is not how another person will react to something so and I have learnt to be patient and understanding and just caring and being empathetic and sympathetic at the same time.” (NC 3-LN: SSI)

"I must say with our nursing campus I think it is one of the best with regard to theory, our lecturer R425 is the course that we are doing it is so packed but they ensure that we understand our syllabus. We have clinical facilitators also every time we go to the ward they are present. If I say I saw a certain condition, I do not understand our clinical facilitators will come and explain to us." (NC 1-LN: SSI)

Nurse educators and nurse managers also shared their viewpoints regarding the theoretical experiences and their views are noted below:

"More emphasis must be put on ethics and professionalism. Our products do not have any professionalism." (CF 2-NM: FG)

"In the Fundamental Nursing Science and in the Introduction to the Ethos and the Professional Practice and you explain to them that nursing is unique because it's a caring profession. It is one profession where you need to be able to communicate and you need to be able to show your caring." (NC 2-NE: FG)

"I think that nurses' pledge we remind them of their first year when you say you are caring because you also ask I solemnly pledge myself to the service of humanity, you are saying I'm going to be caring, I'm going to be doing whatever I can, I'm going to be available, I'm going to help, I'm going to be an advocate for you and then you say I will hold in confidence everything I will be showing respect which actually caring because that person while they are in the hospital." (NC 3-NE: FG)

6.7.2 Clinical learning experiences-opportunity to practise caring

All the participants in the study shared their views regarding the clinical learning experiences- opportunity to practise caring in the CLE and articulated that they experience challenges with the integration of the theory into practice. The following are the caption of the statements by the learner nurses:

“When clinical facilitators are doing demonstration in the demonstration room, first of all, we use gimmick it does not respond it just there. When we get to the ward much it is just different it is frustrating. We end up doing things which we call “the ward style” as in we follow their trends, and things that they do are not right because what we learn from college is so different and sometimes it is so hard to integrate the theory into practice.” (NC 1-LN: SSI)

“In public hospitals, the environment is not very conducive to the development of this human caring attribute. There is a lack of resources both human and equipment.” (NC 2-LN: SSI)

Nurse educators also shared sentiments with their students in the regard of nursing students encountering challenges when they try to integrate the theory into practice and this is observed in the excerpts below:

“When my students last year they started training, their first exposure in the wards, there was nobody to mentor them. No private students, no red buttons, no green button, no senior students, because of reduced intake. Do you see the direct impact of these budgetary constraints?” (NC 2-CF: FG)

“The students have to put the theory that was taught at college to practise in the clinical learning environment. They find a different environment, where they cannot correlate what was taught theoretically into practice, because of shortage, they don’t find themselves being students in the CLE. They find themselves filling in gaps or used as a workforce.” (NC 1-CF: FG)

6.7.3 Student nurses’ role in the clinical learning environment

All the participants in the study shared their views regarding the need to redefine the role of the learner nurses in the CLE. The participants were of the view that nursing students do not only fill the gaps for the permanent nursing staff, but they also serve as messengers and porters as well. The following are direct statements by nurse learners:

“First and foremost is that as a nursing student we should not be used to substitutes or cover up for the shortage of nurses.” (UoT 1-LN: SSI)

“Like us the fourth years we are regarded as professional nurses so that is a burden because I no longer have that privilege of working under supervision as a student nurse.” (NC 1-LN: SSI)

“So if like there are five permanent ward staff and are given students they will be like oh thank God we are given students so now we are covered. Staff absenteeism is huge up there. In certain areas ‘yes’ we can give beautiful nursing care to our patients. We can attend to all of their needs but there are certain wards where staff does not want to be allocated in. So, those wards are seriously understaffed to a point where we will be doing bed baths till 13h00 pm. Even the unit managers are bathing with us because it is a surgical ward.” (NC 3-LN: SSI)

*“They (the students) would tell you that ‘whoa! **(Taking a deep breath)** Other registered nurses don’t care about your level of training even if you are at this level (4), they still want you, you to be a messenger. We don’t get the chance to learn administration, to learn the professional practice.” (NC 2-LN: SSI)*

Nurse educators shared sentiments with their learners and said:

“When the nursing students are located in the clinical area, are not taken care of by the permanent staff as students. It is not that the operational managers must do the staff teaching themselves, but they must allocate or delegate other professional nurses in their units to teach. There are days in the wards where there are no doctors and no theatre then those are the days to be utilised for staff teaching.” (NC 4-NE: FG)

“Students are used in the clinical area; they are being sent as porters sometimes to X-rays etc. You know they don’t get a chance really to practise as students.” (NC 2-CF: FG)

6.8 MAJOR THEME 5: WORKING ENVIRONMENT AND DEVELOPMENT OF HUMAN CARING ATTRIBUTES

The participants in the study were asked about their viewpoint regarding the clinical working environment and the development of human caring attributes. The findings were that: a) un-conducive working conditions, b) low staff morale and c) the hospital management issues. A description of these perceptions follows hereunder.

6.8.1 Un-conducive working conditions

All the participants in the study shared the opinion that the current working environment does not support the development of the human caring attributes from the learner nurse. The following are the direct statements by the learner nurses:

“No, because we, students are treated as staff. I would not say the environment is conducive to learning because we end up not learning anything as students. For instance, as a third-year student, I am expected to do administrative work mostly but sometimes I do not get a chance of doing that due to staff shortage.” (UoT 1-LN: SSI)

“The environment in the clinical area does not support the development of this human caring attribute. I do not like the environment in which we render care in and because this hospital is infected with monkeys.” (NC 1-LN: SSI)

“We are taught to spend time with patients to find out what exactly how they are feeling to go in-depth with their condition. In the wards, we do not get that chance honestly speaking. We are taught one thing and when we go to the ward it is different.” (NC 4-LN: SSI)

Nurse educators and nurse managers shared their opinion regarding the working environment and the development of the human caring attributes and their opinions are noted below:

"You know a lot of our public hospitals are uninviting from the gate because of the state of cleanliness." (NC 3-NE: FG)

"I have had two if not three incidences of healthcare workers who are not necessarily nurses who had been attacked at work by the public." (CF 1-NM: FG)

"No, it does not promote the development of the human caring attribute, it is gone." (NC 4-SNE: FG)

6.8.2 Low staff morale

All the participants shared the opinion that staff morale in the clinical learning environment was reduced significantly due to lack of resources some nurses opt to absenteeism rather than being on duty according to them. The following are the direct statements by the learner nurses:

*"I was **(looking very sad)** I was flabbergasted I was like really? We lost a seventeen-year-old young guy who still had his whole life ahead of him. To be honest, what the lecturers are doing, they are doing the best that could be done. Our clinical lecturers and theory lecturers do come to accompany us. They will come to the ward and say how do you feel? Are you okay? Are you coping?" (NC 1-LN: SSI)*

"It is because of the peer pressure, the feeling of I just want it to be done, I do not care how it gets done as long as it is done." (NC 2-LN: SSI)

"Sometimes I feel like some nurses absent themselves from work because they are overwhelmed and overworked." (NC 3-LN: SSI)

Nurse educators and nurse managers shared their opinion regarding staff morale and the development of the human caring attributes and their opinions are noted below:

“As they say “give the carpenter his tools”- give the nurse the infrastructure.”
(NC 2-SNE: FG)

“I never had an opportunity of seeing a child dying in the ward as much as our students are seeing it nowadays.” (NC 3-SNE: FG)

“Nurses at some point have to write their names on the disposable plastic aprons so that they will re-use them.” (CF 3-OM: FG)

6.8.3 Hospital management issues

All participants believed that there is a need to revisit how the hospitals were managed, to improve the quality of patient care. The following are the direct statements by the learner nurses:

“I feel like our management is failing us big time. Our matrons will come and say that is wrong, that is wrong but they know very well what causes all these problems. Eish! I wish that the hospital CEO could have a nursing background, not doctors because they know nothing about nursing they do not understand it they have never been nurses.”

Nurse educators and nurse managers also shared their opinions in this regard and said:

“Political leaders and all of the people on top management at the provincial and national level can make lots of rules and regulations unrealistically. They are not seeing what is happening down here at the operational level. So their decisions are just good on paper”. (NC 1-NE: FG)

“Some politicians instead of dealing with health care workers’ challenges, they decide that nurses are misbehaving because of the colour of their uniform.”
(CF 3-OM: FG)

"We need to go back to the old system where we had the doctors being in charge of the hospital, nurses being in charge of not just getting any other person." (NC 3-SNE: FG)

"They standardised certain activities, certain things like if you are going to order something you cannot just order and get it immediately as you might need or within a short space of time because they have to follow the protocol." (NC 3-CF: FG)

"Some people are leaving either due to resignation, retirement or death but they are not replaced due to moratorium because of those politicians taking decision on our behalf." (CF 1-OM: FG)

"It is frustrating because it is hard to keep up with the human caring attribute when you are overloaded with work and you find it difficult to purchase things for your department because there are no finances." (CF 2-NM: FG)

"The paperwork is killing us. I feel like there is too much paperwork." (CF 3-NM: FG)

6.9 MAJOR THEME 6: MEASURES TO ASSIST AND SUPPORT NURSE EDUCATORS AND NURSING STUDENTS ENGAGING IN NURSING EDUCATION AND TRAINING TO IMPROVE THE QUALITY OF PATIENT CARE

The participants were asked to share their opinion regarding the measures that can be put in place to assist and support nurse educators and nursing students engaging in nursing education and training to improve the quality of patient care. The participants described the measures that can be put in place to assist and support nurse educators and nursing students engaging in nursing education and training to improve the quality of patient care as a) the revival of the hospital-based Clinical Teaching Department, b) the role of nurse educators in the clinical teaching, c) the role of nurse educators in the

clinical teaching, d) the confirmation or feedback, e) the pre-exposure to the ward's situation for all the applicants. Their responses follow hereunder.

6.9.1 Revival of the hospital-based Clinical Teaching Department

All participants in the current study believed that there is a need to revive the clinical teaching departments that are hospital-based, to assist the nursing students not only with competency but with the emotional support as well according to them. The following are the direct statements by the learner nurses:

“When we are in the wards it feels like we are just thrown into deep waters.”
(UoT 1-LN: SSI)

“Those hospitals based clinical facilitators they will go to the ward and monitor all the nurses.” (NC 3-CF: FG)

“There is a need to strengthen the clinical teaching that is based in the hospital.” (NC 3-NE: FG)

“Our students need a person who is going to be there with the nursing students almost every day from morning till they knock off.” (NC 3-SNE: FG)

“Why are these facilitators based at college? We need to revive the preceptors and mentors because we do not have time to teach. Both lectures and clinical facilitators need to be visible as well. I think preceptors should come back. We must have preceptors in the wards and the very active clinical teaching department in the hospitals.” (CF 3-OM: FG)

6.9.1 Role of nurse educators in clinical teaching

All participants in the current study cited that the clinical instructors and lecturers should be more visible and involved in the clinical learning area so that they can assist with their expertise as researchers and educators. The following are the direct statements by the learner nurses:

“As for clinical accompaniment and support from college is good we do get support, but even though our lecturers do come and check on us it is like sisters put on a good face for the lecturers but as soon as they turn their backs we are used as ward staff.” (NC 1-LN: SSI)

Nurse educators and nurse managers affirmed and said:

“I feel like the nurse educators are doing enough when it comes to our lecturers with the support if we have any issues they are always there to help us.” (NC 2-LN: SSI)

“The clinical instructors and lecturers should be more visible and involved in the ward.” (CF 1-NM: FG)

“Unlike now as nurse educators only come to the ward to accompany students or to do assessments that is all they are gone. At this present moment we have only fifteen nursing students at the college. All those clinical instructors are at the college, doing what? Our tutors were always on the floor with the students, unlike these. They taught us how to do admissions and how to do a bed bath. They were always there all the time.” (CF 1-OM: FG)

“So, what is the use of having students allocated in a paediatric ward but when they are doing assessment they take them away.” (CF 1-OM: FG)

“I have noticed that there is a barrier that is created between the lecturers/ clinical facilitators and the ward sisters. When you are in the ward the trained

staffs see nurse educators as a monster or a monitor who is there to see the wrong things that are done in the ward. We need to revive the up and running clinical teaching department.” (NC 4-SNE: FG)

6.9.2 Confirmation or feedback

The participants in the current study believed that area nurse managers need to recognise and reward good behaviour from their staff to re-enforce it. Learner nurses did not have an input in this regard. The following are the direct statements by the nurse educators and nurse managers:

“Sometimes we as nurse managers fail to reward good behaviour.” (FC2-OM: FG)

“If we can learn to recognise minor things like for example, punctuality.” (NC 4-SNE: FG)

6.9.3 Pre-exposure to the ward's situation for all the applicants

The participants in this study recommended pre-exposure to the ward's situation for all the applicants before the beginning of the actual training. Some participants in this study recommended that schools should allow grade 10 pupils to come to do experiential learning in hospitals so that they have an idea of what being a nursing entail, before being admitted to training. This is noted in the excerpts below:

“The applicants for nurse training need to be exposed to the wards, first before they are admitted to training. So, they can decide whether they like nursing or not. That will show them exactly what is in store for them. Some people think that for a person to become a nurse, they only sit behind the desk and do paperwork or only administer oral medication.” (NC 3-NE: FG)

“Schools actually should allow them to do experiential learning in hospital from grade 10, so that they see what does nursing entails before they are admitted into training.” (CF 1-OM: FG)

6.10 SUMMARY OF THE CHAPTER

This chapter provided the presentation of qualitative data findings. The findings of the current study revealed that there was a unanimous agreement amongst the nurses irrespective of their professional ranks about the understanding of the concept of human caring. Six major themes were identified in this study namely: the meaning of the concept, the skills and abilities that are needed to be successful at caring, the factors related to the development of human caring attributes, the experiences that contributed towards the development of human caring attributes and the measures that could be put in place to assist and support nurse educators and nursing students engaging in nursing education and training to improve the quality of patient care. The findings revealed the positive and negative experiences in both the theoretical and the clinical learning environments, and their opinion regarding the ideal clinical and theoretical learning environment. In the next chapter, the interpretation of both the quantitative and qualitative results will be presented in the combination of graphs and themes as well as the mixing of the two data strands.

CHAPTER 7: DISCUSSION OF FINDINGS

7.1 INTRODUCTION

In Chapter 5, quantitative results were presented and in Chapter 6 qualitative outcomes were presented. This chapter focuses on the discussion of the results. The discussions of the results are guided by the study objectives as described in the first chapter, the Watson's caring theory and the Noddings (1984) teaching model, as well as the themes that emerged from the analysis focus groups interviews of nurse educators and nurse managers and semi-structured interviews and of newly graduated professional nurses and nursing students as well as questionnaire responses. The investigator delivered explanations of what the participants designated in the deliberations and the quotations that were demonstrative of the themes. The deliberations emphasised the association amongst the confirmation delivered by the literature appraisal and the consequences attained from the present investigation. The investigator will now debate the precise implications of the discoveries concerning the role played by theory and practical learning experiences in influencing the development of human caring attributes among undergraduate nursing students and newly graduated professional nurses, the implications to the existing literature, henceforth credibility of the interpretations of the findings.

7.2 OVERVIEW OF THE RESEARCH DISCUSSIONS

The convergent mixed method design (Qualitative + Quantitative) was utilised to assess elements from both qualitative and quantitative paradigms due to the behavioural aspect of the study (Polit and Beck 2017: 724). This method allowed the researcher to use simultaneous timing to instrument the qualitative and quantitative components in the course of the similar investigation procedure, prioritised both approaches by the same token, but kept the components independent and only mix the quantitative and

qualitative results during the overall interpretation (Creswell and Creswell 2018: 217). The determination of using the convergent strategy was to attain diverse but congruent information on the expansion of human caring attributes amongst the nursing students to enable the researcher to acquire the best possible understanding of the research problem (Creswell and Creswell 2018: 216). According to Creswell and Creswell (2018: 4), mixed methods research is a method to investigation comprising gathering both quantitative and qualitative information, incorporating both methods of information, and utilising divergent approaches that may encompass logical supposition and theoretical structures. The fundamental supposition of this method of investigation is that the amalgamation of qualitative and quantitative methodologies delivers a supplementary comprehensive comprehension of an investigation problematic. A mixed-method investigation strategy was elected for this study because solitary information basis was inadequate to completely response the investigation interrogations. The study sought to critically analyse the role played by theoretical and clinical learning experiences in influencing the development of human caring attributes amongst the undergraduate nursing students and newly graduated professional nurses (less than five years of experience) in KZN to establish clear guidelines that can be used by lecturers to enhance the human caring attributes among the nursing students.

The quantitative data aimed to accomplish the initial goal of the investigation which was to assess the nursing students' and the newly graduated professional nurses' understanding of the concept of human caring. In the present investigation, the Caring Behaviour Inventory Tool by Wolf (2017) was adopted by the investigator after receiving authorisation from the writer and was used for the quantitative strand. The CBI-42 was originally developed in the perspective of the caring philosophy, chiefly the literature of Watson, 179 in the late 1970s and (Watson, 1988) 1980s and Gaut (1983: 313-324). The initial testing consisted of a nurse sample (Wolf, 1986). It was subsequently administered to adult patients and the nursing staff (Wolf *et al.* 1994). The CBI's theoretical definition focused on measurement of the perception of nurse caring. Caregiver compassion was demarcated as a collaborative and

inter subjective e progression that transpires all through instants of communal susceptibility amongst the caregiver and the care receiver, and that it is mutually self- and other persons focussed. Kind-heartedness point in the direction of the well-being of the care receiver and occurs when carers attend care-receivers in a considerable state of affairs (Wolf *et al.* 1994: 107). This definition was supported by the frameworks of Gaut (1983: 313-324) and Watson (1979).

The qualitative data aimed to achieve the first, second, third, fourth and fifth objective of the study which were to assess the nursing students', newly graduated professional nurses, nurse managers and nurse educators' understanding of the concept human caring, explore and describe the intrinsic and extrinsic factors related to the development of human caring attributes from the perspective of the nursing students, newly graduated professional nurses (less than five years of experience) and nurse educators, determine the nursing students' and newly graduated professional nurses (less than five years of experience) experiences in both the theory and the clinical setting that contributed to the development of human caring attributes according to their perspective, to explore and describe skills and abilities that are needed to be successful at caring from the perspectives of the participants and to determine the association between the working environment and the development of human caring attributes. The qualitative aspect allowed the researcher to gather information from the newly graduated professional nurses (less than five years of experience) and nursing students' from both institutions understudy, through semi-structured in-depth interviews and through focus group discussions from the nurse educators from DUT and KZN CN as well as nurse managers (including unit managers and deputy managers) from facilities where newly graduated professional nurses (less than five years of experience) and nursing students from HEI and NEI understudy practice.

In this study, Watson's caring theory and the Noddings (1984) teaching model were used as an organising framework. Watson's Caring Theory shaped the nature of interrogations to be probed to the respondents (Creswell and Creswell. 2018: 72). The researchers ought to construct a perfect theoretical explanation of their fundamental variables, thus giving facts regarding the scholarship's structure (Polit and Beck 2017: 119). Noddings (1984), one of the foremost philosophers to clarify compassionate representations in coaching, cited that there are four dominant mechanisms in coaching compassion. These comprise (a) modelling, defined as an exhibition of kindness for the learner to acquire the skill of caring; (b) dialogue, which comprises a sincere flexible conversation and deliberated conduct that validates kindheartedness; (c) opportunity to drill compassion; and (d) validation or response to the compassionate occasion. Numerous investigators decide that compassion is acquired by encountering compassionate collaborations with NEI in an environment backed by optimistic compassion NEI/ HEI -learner associations (Eley, Eley, Bertello and Rogers-Clark 2012; Gaines and Baldwin 1996; Tanner 1990; Watson 2008). There is no single theory that is an exact fit of any enquiry, hence the researcher should substantiate the choice of a theory that aligns and frames the purpose, research questions, significance and design in the study.

7.3 SYNTHESIS OF FINDINGS FROM DIFFERENT DATA COLLECTION INSTRUMENTS

The discoveries from the dualistic components of the investigation were presented independently, but the integration of results provide comprehensive insight into caring practices to establish clear guidelines for lecturers and the clinical facilitators to be used to enhance human caring attributes among the nursing students. The joint interpretation of the quantitative and qualitative results highlights the issues relating to the development of the human caring attributes amongst the nursing students. In Table 7.1 below, the summary of findings from all data instruments will be presented.

Table 7.1: Summary of findings from all data collection instruments

Qualitative: focus group discussions and semi-structured interviews		
Theme no	Major themes	Sub-themes
1	Meaning of human caring.	1.1 Need for a person to be cared for. 1.2 Human caring as showing the patient respect and the dignity. 1.3 Human caring as being sympathetic and empathetic with the patient. 1.4 Human caring as a skill. 1.5 Human caring as helping. 1.6 Human caring as nurses showing care and concern for patients. 1.7 Human caring as therapeutic use of self.
2	Skills and abilities that are needed to be successful at caring.	2.1 Effective communication skills. 2.2 Professional competency: Knowledge about nursing procedures. 2.3 Triaging skills: clinical reasoning. 2.4 Emotional intelligence. 2.5 Respect for another human being.
3	Factors related to the development of human caring attributes.	3.1 Intrinsic factors. 3.3.1 Primary socialisation. 3.2 Extrinsic factors. 3.2.1 Previous experience of the nurses as patients or patients' relatives. 3.2.2 Selection of nurses for training/ the reasons of joining nursing profession. 3.2.3 Religious beliefs and cultural background of a nurse. 3.2.4 Inappropriate use of gadgets by nurses. 3.2.5 Peer pressure from other colleagues. 3.2.6 Impact of the rise in the number of social ills in our communities. 3.2.7 Lack of support mechanism from nursing management and NEIs management. 3.2.8 Role models' behaviour. 3.2.9 Gross shortage of the human and material resources. 3.2.12 Negative attitudes towards nurses. 3.2.13 Negative publicity about the nursing profession. 3.2.14 Nurses' rights versus patients' rights.
4	The experiences that contributed towards the development of human caring attributes.	4.1 Theoretical experiences 4.2 The clinical setting experiences
5	Working environment and the development of human caring attributes.	5.4 Un-conducive work environment. 5.5 The hospital management issues. 5.6 Low staff morale.
6	Measures to be put in place to assist and support nurse educators and nursing students engaging in nursing education and training to improve the quality of patient care.	6.7 Revival of the hospital based Clinical Teaching Department. 6.8 Counselling and emotional support for nurses'/ student nurses. 6.9 Confirmation or feedback. 6.10 Pre-exposure to the wards situation for all the applicants.

The Caring Behaviour Inventory Tool Results					
Caring behaviour top 10 ranks ordered are explained below:					
No	Item No	Individual item	Dimension of caring	Mean	SD
1	8	Showing respect for the patient	Respectful deference	3.71	.593
2	28	Treating patient information confidentially	Respectful deference	3.65	.595
3	7	Giving the patient information so that he/ she can make a decision	Respectful deference	3.60	.600
4	38	Giving the patients' medication on time	Respectful deference	3.59	2.311
5	41	Putting the patient first (patients are my priority)	Attentive to other's experience	3.55	.658
6	36	Helping to reduce the patients' pain	Assurance of human presence	3.54	.617
7	18	Helping the patient	Assurance of human presence	3.52	.628
8	35	Appreciating the patient as a human being	Assurance of human presence	3.52	.618
9	9	Supporting the patient	Respectful deference	3.52	.603
10	15	Making the patient physically or emotional comfortable	Respectful deference	3.52	.623

Caring behaviour lowest 12 ranks ordered are presented below:					
No	Item No	Individual item	Dimension of caring	Mean	SD
1	33	Meeting the patients' stated and unstated needs	Assurance of human presence	3.29	.682
1	17	Being patient or tireless with the patient	Assurance of human presence	3.29	.683
1	34	Responding quickly to the patients' call	Assurance of human presence	3.29	.697
1	39	Paying special attention to the patient	Attentive to others' experience	3.29	.684
2	23	Watching over the patient	Assurance of human presence	3.28	.651
3	30	Returning to the patient voluntarily	Assurance of human presence	3.27	.713
4	24	Managing equipment skilfully	Professional knowledge and skill	3.26	.688
5	25	Being cheerful with the patient	Positive connectedness	3.23	.673
6	14	Helping the patient grow	Positive connectedness	3.22	.660
7	4	Spending time with patient	Positive connectedness	3.11	.747
8	5	Touching the patient to communicate	Positive connectedness	3.01	.716
9	12	Trusting the patient	Positive connectedness	2.93	.779

7.4 EVALUATION OF FINDINGS

The quantitative data showed that nursing students and newly graduated professional nurses had a clear idea regarding the constituents of caring in nursing. The findings identified a caring nurse as being giving the patient information so that he/ she can make a decision, supporting the patient, giving good physical care, giving instructions or teaching the patients, treating patient information confidentially, making the patient physically or emotional comfortable, helping to reduce the patients' pain, encouraging the patient to call if there are problems, showing respect for the patient and giving good physical care.

The lowest mean responses rates were noted for the following 12 responses because the four of them were the same in terms of mean and could not be separated: meeting the patients' stated and unstated needs, being patient or tireless with the patient, responding quickly to the patients' call, paying special attention to the patient, watching over the patient, returning to the patient voluntarily, managing equipment skilfully, being cheerful with the patient, helping the patient grow, spending time with the patient, touching the patient to communicate and trusting the patient.

Four dimensions of caring were identified in this study. The highest dimension of care identified in this study Respectful Deference to Others is considered a significantly more caring behaviour than the others = 233.702, $p < .0005$, whilst Positive Connectedness was considered less of caring behaviour. There was a significant agreement that 'attentively listening to patients' is a caring behaviour, $Z = -13.882$, $p < .0005$. There was no significant difference across RACE and marital status. However, there was a significant difference in how people of different religions regard Respectful Deference to others as caring behaviour, $\chi^2 (3) = 9.460$, $p = .024$. Christians regard it as more of a caring behaviour than do Nazareth's. There is a small negative correlation between age and the perception of whether Positive Connectedness was a caring

behaviour, $\rho = -.171$, $p=.002$. Younger age is associated with a higher agreement that this is a caring behaviour.

The discoveries of the present investigation are incongruent with the research conducted by Kilic (2018: 402-405) in their scholarship explored the compassionate opinions of learner nurses who were registered in the basic prospectus. The discoveries validated normal mean score for CBI was 5.13 ± 0.52 . Mean scores for the sub-dimensions of the scale were 5.18 ± 0.58 for assurance of human presence, 5.22 ± 0.54 for knowledge and skill, 5.03 ± 0.87 for respectful deference to others, and 5.08 ± 0.66 for positive connectedness. While the item “performing treatment and medication on time” was the most scored item by the participants, listening to patient attentively was the least scored ones. In her study knowledge and skill, sub-dimension was indicated significantly high by the participants whose age ranged between 18 and 20 ($p < 0.003$). Nursing learners were found to indicate “performing treatment and medication on time” as the most caring behaviour in the most several other studies (Khademian and Vizesfar 2008: 456-462 and Zamanzadeh, Valizadeh, Azimzadeh, Aminaie, Yousefzadeh 2014: 93-101).

The CBI-42 (Wolf *et al.* 1994) integrates an assumption that the conduct constructing the inventory distinguish the more communicative characteristics of compassion. There are no negatives on the scale; all the objects communicative appreciated characteristics of consideration intending with which the participant is summoned to express the stage of contract amongst strongly agreeing and strongly disagreeing. Nonetheless, the construction of the instrument and the standardised course tends to modest in support of extraordinary counting revenues. For instance, it is challenging to envisage any learner nurses discordant, intensely discordant with declarations such as “meeting the patients’ stated and unstated needs” and “being patient tireless with the patient” (CBI items 33 and 17). Some of the counting consequences of the present scholarship were unanticipated.

Listening is unanimously acknowledged as the determining factor of the curative association (Scott *et al.* 2008: 320; College of Nurses of Orlando 2009: 3). Babler-Schrader and Babler (2011: 370-375) conducted the quantitative investigation amongst the 103 caregivers to estimate their gradation of proficiencies concerning the influential, interactive and self-representational expertise in the course of their collaboration with clients. The interactive expertise discovered the incidences of enthusiastic performances such as emergent relationship, instituting confidence, pay attention to and collaborating efficiently. Of the 590 declarations that were created from the content exploration, only 14 were related to paying attention and communiqué expertise. It is apparent that regardless of the understanding that communiqué and pay attention are critical in the rapport, they are not operative practices in the day-to-day dealings with the recipients of care.

7.5 MAJOR THEME 1: MEANING OF HUMAN CARING

In a qualitative strand, the participants were asked about their understanding of the concept of human caring. The participants provided a description of their perception of human caring which included the meaning of human caring as a) need for a person to be cared for, b) human caring as showing the patient respect and the dignity, c) human caring as being sympathetic and empathetic with the patient, d) human caring as a skill, human caring as helping, e) human caring as nurses showing care and concern for patients and f) human caring as the therapeutic use of self.

7.5.1 Need for a person to be cared for

Most participants in the current study perceived human caring as meeting patients' needs. The results of this study show that human caring stem from the right attitude from the nurses and it is accompanied by positive actions confirming it. They also stated that there must be an identified altered need that is perceived as such by both the nurse and the patient for the care to be implemented.

This is congruent with the Caritas process number 6. Watson (2009: 146) affirms that help with the satisfaction of human requirements is realised as “supporting with elementary requirements, with a deliberate caring realization, directing human care fundamentals which potentiate configuration of the physique, mind and soul, comprehensiveness and harmony of existence in all aspects of care, have a tendency to both personified soul and growing divine development. The caregiver s has the accountability to investigate from the client if there are any trials for the client necessitates support with the rudimentary requirements, they should be rendered with admiration such as avoiding preventable exposure of the client because he is incapable of clothing himself. The caregiver should uphold the deliberate, caring cognizance of touching the embodied soul (Watson 2009: 146). Therefore, all nurses must possess the necessary skills for them to be able to meet the patients’ needs.

7.5.2 Human caring as showing the patient respect and dignity

The respondents in the present investigation perceived human caring as showing patient respect and dignity. Participants in this study also cited that human caring is perceived as showing respect and dignity to a fellow human being. Other participant defined human caring as human interaction in a respectful manner. Individuality was also emphasised when caring for human beings by the participants in this study. These findings are congruent with the quantitative findings of the current study where showing respect for the patient was rated amongst the top ten items (item number 8). Four dimensions of caring were identified in this study. The highest dimension of care identified in this study Respectful Deference to Others is considered a significantly more caring behaviour than the others = 233.702, $p < .0005$, whilst Positive Connectedness was considered less of caring behaviour. Therefore, showing patient respect and dignity was a similar finding in both the quantitative and qualitative findings.

7.5.3 Human caring as being sympathetic and empathetic with the patient

The majority of the participants perceived human caring as being sympathetic and being empathetic with the patient. According to the participants in this study, human caring means being able to sympathise and empathise with the patient. Sometimes nurses have a problem of finding the balance between the act of empathising or sympathising with the patient without being emotionally drained according to participants in this study. Participants in this study also stated that getting too close to the patient to an extent that should there be a negative outcome to the patient the nurse would not be able to function was not good for the nurse.

These findings are congruent with the Watson (2008: 82) theory of caring which stated that sympathy as conception has also been well-thought-out as the contributing factor of well-organised communiqué and listening expertise. Understanding has been recognised as intellectual expertise, which permits the caregiver to have the capability to deduce the state of affairs from the client's viewpoint. Understanding permits, the caregiver to interrelate in a way of transmitting the acknowledgement of the clients' desires and apprehensions. Sympathy includes the considerate that the clients' viewpoint of the circumstances. In the progression of sympathising with the client, the caregiver remains objective; reacts in a caring manner, inculcating hope in the client and establishing information, expertise and experience in managing the issue at hand (Watson 2008: 82).

7.5.4 Human caring as a skill, human caring as helping

The participants in the current study perceived caring as providing help to another human being in a skilful manner. Human caring is a very important skill that all nurses should possess throughout their life according to the subjects in this study. The respondents also said for the nurses to be able to render effective care support from their seniors was cited as very important. Human caring was regarded as helping another human being who requires

help in this study. When rendering care on another person nurses should do it the way they would like to see things being done to them. Humanness should be evident when the human being is helping another human being according to the participants in this study. Leininger (1981b: 7) affirms that the concept of care seems crucial to hominoid growth, expansion, and existence for humans for many years. Compassion seems to be the mainly unidentified component for assisting others under the risk of ailment in a humanistic and technical mode.

7.5.5 Human caring as nurses showing care and concern for patients

The majority of participants perceived human caring as nurses showing care and concern for patients. According to participants in this study loving what you are doing as a nurse is very important. Caring for the patient should not only focus on the physical needs of the client but should also focus on all the other needs of the client. Nurses should take responsibility and be accountable when caring for the care receiver. The participants in the study also cited that when nurses are giving the best and the honest kind of care that they are supposed to give to the other person. The respondents in the current study said human caring means nurses showing love and concern to the patients in every possible way. They also said the involvement of the family or loved ones play a major responsibility in helping care receivers. Families need to be knowledgeable and updated about the patients' during hospitalisation and beyond to enable them to render the necessary support.

Gillian (1982: 62) argues that the caring standpoint is illustrious by an apprehension of care, receptiveness and taking accountability in interactive relations and by the context-sensitive approach of negotiation that struggles intellectual constructions of ethical difficulties. This author identified that the idyllic compassion is, an action of associations, of seeing and reacting to necessity, taking care of the realm by nourishing the network of association so that no one is left without help (Gillian 1982: 62).

7.5.6 Human caring as the therapeutic use of self

All the respondents in the present investigation believed that a nurse must use herself as a therapy to another human being. In other words, it's not about the nurse relying on the medication that nurses given to patients, nurses as human beings, who care for patients but also use themselves as, a therapy. The participants in this study also stated that patients should feel that there comes our nurse and because of the nurse wearing a smile because of the nurse showing love to her profession showing the love of work, showing all those things that a patient would like to see. Some respondents in the investigation cited the significance of involving and listening to the patients' relatives when caring for the patients. Nurses' actions and appearance should express their love for their work and nurses should be always portraying the positive emotions.

Current findings can be compared to Watson's Caritas Processes number 6. Orderly usage of an imaginative problematic resolving considerate progression develops "inventive usage of self and all means of deliberate as part of the caring progression, to involve in the creativity of caring-healing practices". Inventiveness in planning the clients' care will necessitate an aspiration to ascertain and realise the tactics that construct on that exclusive feature of the care receiver (Carusso, Cisar and Pipe 2008:128). The curative usage of self by the skill of involving the client in the procedure of generating a compassionate curative practice is crucial (Watson 2009: 44).

Results of the present investigation are incongruent with the findings of the existing body of knowledge. Discoveries of the scholarships on carers' perception of compassion performances recognised communicative conducts as pointers of carefulness more regularly than influential conducts. These comprised the significance of carers' kindness and communication expertise (Forrest 1989: 815-823; Clarke and Wheeler 1992: 1283-1290; Nyberg 1990: 13-18). According to Pepin and Cara (2001: 33-46), caring is formed by the mixture of activities and establishments that permits a caregiver to use his/her

expertise to interpret any no-verbal cues suggesting that the well-being of the human beings have a predisposition to recuperate or get worse. Caring is not an inactive, motionless set of involvements taking place in exclusion and lacking resilient association to the situation in which it comes about (Anderson, Williams, Sjöström-Strand and Borglin 2015: 1-10).

Nurses in a scholarship by Anderson *et al.* (2015: 1-10) professed consideration as the action that direct to either assistance or enhancement of indications and improved healthiness. The key fundamentals in describing compassionate associations have been established to be care receiver focused consideration, kind-heartedness, efficient communication, backing/ sponsorship, well-versed contribution and assisting healthcare users' elementary desires (Joolaei, Joolaei, Tschudin, Bahrani and Nikbakht Nasrabadi 2010: 4). Griffin (1983: 289-295) identified that there were dual balancing features of caring in nursing: the actions feature and the approaches and the emotional state foundation them. The actions characteristic was the 'responsibility' on the side of compassion. This intricate all the hands-on actions that caregivers affianced in while performing nursing procedures. The outlooks and emotional state characteristic implicit more than the official obligation of the nursing duty. It encompassed intellectual, expressive and ethical fundamentals of caring which were reliant on the individual engrossment of caregivers and the restrictions in their exertion. The collocation of these two features might create an equivocal situation or burden for caregivers in circumstances when conciliation amongst these two could not be grasped. In a study in Hong Kong, according to Yam (2000: 16) caregivers in her investigation treasured the significance of expressive behaviours and the interactive expertise in universal client care. Her investigation also revealed the troubling secret language of caregivers' caring capabilities being inadequate by a healthcare system which is progressively being precious by the financial constraints, managerial control and the technical improvements. These issues can undervalue the humanistic worth of nursing.

Morrison (1991: 3-12) recognised seven classifications that could offer a comprehensive depiction of consideration. These were individual capabilities, experimental exertion elegance, interactive tactic, level of inspiration, compassion, use of time, and outlooks. Observing these critical abilities emphasised the inclination of expressive behaviours, alike to those found in American investigations (Yam 2000: 3). When observations of caregivers caring attributes of both the clients and caregivers were associated Larson (1986: 187-193) and Mayer (1987: 48-52) reported a numerical momentous variance amongst the two crowds in the same oncology location. As in their results in exploration scholarships investigating the two groups independently, clients usually treasured proficient experimental expertise as being more significant than communicative activities in transmitting caring, while caregivers categorised communicative activities upper. Regardless of their diverse prominences, the universal covenant was that caregivers were expected to exhibit the experimental proficiency in nursing and rendering corporal care to clients before their communicative attributes became treasured by clients. Through providing the physical necessities of the clients, caregivers could augment the occasions for a caring association in their clinical surroundings.

7.6 MAJOR THEME 2: THE SKILLS AND ABILITIES ARE ASSOCIATED WITH THE HUMAN CARING ATTRIBUTE

The participants were asked to briefly describe expertise and capabilities that are required to be efficacious at compassion from their perspectives, and the findings were that the skills and abilities that are associated with the human caring attribute are (a) effective communication skills and good interpersonal relationship, (b) professional competency: Knowledge about nursing procedures, (c) triaging skills: clinical reasoning, (d) emotional intelligence and (e) respect for human dignity. A description of these perceptions follows hereunder.

7.6.1 Effective communication skills

The result of this study reveals that when the nurses are interacting with the patient it is important for the nurse to listen and maintenance of eye-contact to the patient rather than the nurse to do all the talking. The results of this study also reveal that when nurses are working with human beings it is important that there is proper communication, and procedures should be explained to patients effectively without nurses displaying negative emotions. According to participants in this study, the inappropriate use of technology by the nursing staff on duty hinders proper communication between the nurses and the patients. It also came out in this study that for nurses to survive in this profession they need to know how to communicate effectively without displaying the negative emotion. The results of the FGD show that as much as communication is taught during primary socialisation, informal school as well as in tertiary education but some nurses find it difficult to master that skill. The current study also revealed that nurses must be approachable for patients to be able to communicate with them easily. Nurses are taught about the importance of communicating properly with patients.

The current study confirms the findings of other researchers. Germaine *et al.* (2016: 22) argues *communiqué expertise* refers to the capability to meritoriously express judgements and concepts conveyed orally or through actions, in writing visually or technically in the twenty-first century (Germaine *et al.* 2016: 22). Whist, according to Bach and Grant (2015: 14) *interactive expertise* refers to the associates amongst persons, their association and the manner they act towards each other (Bach and Grant 2015: 14). *Interactive expertise* involves efficient *communiqué*, compassion, paying attention and ethnic proficiency as well as expertise (Skinner, Hyde, McPherson and Simpson 2016: 21). Although, *teamwork proficiency* denotes to functioning effectually and correspondingly within the multi-disciplinary groups applying tractability and enthusiasm to grasp a collective objective as well as tolerating collective accountability and a varied appreciating singular input (Germain *et al.* 2016: 19). This comprises displaying admiration for all characters provided

that comprehensive confirmation or quarrels to sustenance suggested or authentic origination elucidations, whereas functioning within the appropriate specialised, principled and legitimate structure that administer their occupation (Kivunja 2015: 5 and Skinner, Hyde, McPherson and Simpson 2016: 21). This implies that nurses irrespective of their ranks should be able to communicate empathetically and assertively during their engagement with care receivers' relatives, their colleagues and the members of the multi-disciplinary team.

7.6.2 Professional competency: Knowledge about nursing procedures

The results of the current study reveal that participants acknowledged the fact that nurses are assumed to be current about the new expansions in their field. However, there was incongruence between the theoretical and the clinical experiences. It was clear that students expected to integrate their classrooms teachings and skills laboratories into practice in the CLE, however, that was not the case as they found that the nursing procedures were done differently from what they have learnt. This did not only pose a challenge for the nursing students during assessments but the educators as well. This was perceived as a hindrance to effective learning and teaching by mutually the facilitators and the learner nurses. The study also revealed that what they are taught at college is just a fantasy that does not exist in real-world because the nursing procedures are done differently in the wards. The current study also revealed that there is a ward way of doing nursing procedures which are being regarded as quicker than the college way which is time-consuming. It also came with a lot of added frustration and confusion amongst the nursing learners because they had to re-learn the correct way of doing the nursing procedures for assessments purposes only.

The discoveries of the current scholarship are congruent with the conclusions of the scholarship that was done by Kaphagawani (2015: 152), about the learner nurses' clinical learning experiences in selected colleges in Malawi. According to this researcher, the contradictory actualities amongst theory and

practice in the practice milieu were of severe apprehension for learners as it was perplexing and puzzling for their scholarship. It was also remarkable that clashes rose among the undergraduate scholars applying theory into practice according to what the NEI skilled them and do what they were being taught by the qualified caregivers from the practice milieu. Undergraduates were obligated to adapt to the wrong manner of performing nursing procedures by the qualified caregivers in the practical setting. Such situations were found to puzzle the learner nurses as they ended up not knowing which version of performing nursing procedures to adopt (Kaphagawani 2015: 152). According to Gcawu (2012: 61), midwives felt that in the course of training their program of the study had not uncovered to them adequately to the required expertise in the practice milieu. The newly graduated midwives then required self-assurance during proficiency presentation, since they felt that they were unskilled so were dreadful of obstacles that could result in lawsuits. This was also affirmed by the discoveries of Fentainah (2012: 220) which discovered that proficiency is connected with a caregiver /midwives' information, expertise and outlook carrying out allocated occupations competently and carefully. Proficiency is the capability of a caregiver to present information, exhibit expertise and demonstrates outlooks suitably for explicit undertakings in precise circumstances (Fentainah 2012: 220).

The SANC (2013: section 58 (1) [g], states the CLE is very significant for the reason that no NEI can be accredited by the SANC without the recognised CLE. Bruce *et al.* (2011: 253-254) affirms that undergraduates attain expertise and the ethical principles in the CLE. They also integrate theoretical and experimental learning in the CLE. They also learn from clinical experiences with clients. The nursing students obtain understanding excellently in an atmosphere where they are acquainted with established ethical principles so that they transmit their assessment and valuation based on the standardised practice guidelines (Kilminster and Jolly 2000: 827). Senti and Seekoe (2014: 86), state that the practise guidebook which direct learners on how to accomplish nursing procedures at the CLE were obsolete, ancient and not the same as the one at the CLE thus instigating misunderstanding to learner

nurses. Their discoveries were parallel to those of the investigation that was carried out in Iran by Rafiee, Moattari, Nikbakht, Kojuri and Mousavinasab (2014: 41) which discovered that the formative evaluation instruments were not dependable because they were not assessing the learner nurse's attainment and development. According to Bray (2013: 23), affirmed that undergraduates were undergoing trials when integrating theoretical learning into practice because of the assessment approach imparted by the clinical instructor was diverse from what is done at the CLE (Gillian 1982: 62).

Therefore, the discoveries of the present scholarship and the related literature search made the researcher conclude that for the nursing students to be competent and knowledgeable about the performance of the nursing skills there is an urgent for standardisation of the nursing procedures. Collaboration and good relationship amongst NEI's and the clinical learning facilities are mandatory to facilitate the integration of the theory into practice. Periodical review of the procedure manuals including all the teaching materials in the NEI's and the CLE must be done to curb this confusion amongst the nursing students.

7.6.3 Triaging skills-clinical reasoning

The outcomes of the investigation also discovered that for carers to perform their work effectively they need to have the triaging skills. The triaging skills for nurses are paramount regardless of the department they are working in. The current study also revealed that the short staff issue is a problem and it also compromises the excellence of consideration that carers provide to healthcare users because nurses want to attend to that patient but they realise that someone has a more serious issue.

The discoveries of the present scholarship are congruent with the existing body of literature. According to Considine (2004: 516), triaging is the progression of decisive the priority of client's therapy grounded on the rigorousness of their ailment, the distribution of suitable supplies to

accomplish the clients' therapeutic essentials. It also permits for the provision of the client to the most suitable valuation and therapeutic environment (Considine 2004: 516). In this perspective, the word triaging skill was used to refer to the clinical reasoning skill for a nurse to be able to decide which routine to carry out first for which patient. This reality faces nurses daily irrespective of the ward in which they are allocated according to the discoveries of the present scholarship. This is attributed to the gross shortage of human resources. Porter, Corter, Vezina and Fitzpatrick (2014: 817) affirms that financial constraints pressures and restricted resources cause healthcare providers to resolve which tasks to comprehensive and which to the client leave incomplete. Hence, it is integral for the carers to be capable to make that clinical decision regarding the order in which they are going to carry out their duties for all patients to feel cared for; more so that these days there is an alarming scarcity of human resources, equipment and supplies.

7.6.4 Emotional intelligence

The present study revealed that nurses are taught about the importance of being able to express their feelings and thoughts without hurting the next person. When nurse educators teach the nursing students, they in co-operate all the communication skills, but they find that towards the end of the training they say a person must find herself/himself. Nursing students in this study cited that nurses must have stable emotions even when patients are not very easy to deal with. That nurses must have enough emotions to understand the patient in every aspect hectically to understand the home environment now coming to the hospital environment because it is not every patient that is easy to deal with. Some of the patients the nursing students came across were very difficult and the nursing students had to probe and get to make them understand why they were hospitalised and nursing students were only there to help them. The current study also revealed that when the learner nurse is in the ward during visiting hours, families came from all sites and every site, but how professional the nurse carried herself or himself that mattered. If the nurse displayed herself as this angry person somehow the nurse should learn

to deal with his/her anger because the theory has taught them how they should speak to another human being.

According to Watson's theory, Caritas factor three refinement of compassion to the individual's personality and others is believed to be cultivation of one's spiritual practices and transpersonal self, going beyond ego-self. Healthcare providers must progress the expressive intellect. Healthcare provider must begin by appreciating and tolerating her emotional state to enable her to support the client to discover his/her emotional state. Acknowledgement of the ones emotional state will result in the accomplishment of the self-discovery necessity. As the caregiver recognises their compassion, they develop sincerity in distinguishing the emotional state of the clients (Watson 2009: 146).

The discoveries of the present scholarship are incongruent with the existing literature. Chabeli (2006: 78-86) affirms that a neophyte matures a comprehension about the natural surroundings of tending practice and begin to grow a nursing distinctiveness. Scholars enter a nursing career with diverse stages of emotive development and are prone to intensifying pressures and apprehensions connected with nursing education (Chabeli 2006: 78-86). According to Smith, Profetto-McGrath and Cummings (2009: 1629) the nature of nursing forces caregivers to be expressively intellectual. These investigators based their pronouncement on the privilege that healthcare providers are responsible for their care through human associations and therefore, caregivers are answerable for causative in these associations and the state of mind within them. Freshwater and Stickley (2004: 93) argues that nursing curriculum that disregards the worth and expansion of the emotional state is one that repudiates the very heart of the art of nursing career. By concentrating completely on the rational, the nursing career is in the risk of creating unbalanced practitioners. When facilitators do not consider the emotive growth, they fail to interconnect with the undergraduates about the importance of human associations the undergraduates are deprived of the chance of fully developing intelligently.

Therefore, a conclusion can be drawn that nurses who develop emotional intelligence are less likely to succumb to the daily demands of their practice and are more likely to make good clinical reasoning evidenced by good patients' outcomes and less chaotic healthcare environments. The researcher believes that there is a need for all healthcare organisations both public and private to screen their employees for their emotional competence so that all those that are found to be weak in that regard will be equipped and supported.

7.6.5 Respect for human dignity

According to the participants in this study, respect is very important in human caring. Caregivers must be humane to care for another hominid being. Nurses need to possess some certain attributes, which are respecting and treating other human beings with dignity. The discoveries of the current scholarship are consistent with the existing literature. Steviano, Marinis, Russo, Rocco and Alvaro (2012: 341-356), argues that there are dual distinct characteristics of human respect that were acknowledged, comprising inherent hominid self-worth and proficient (social) self-worth. Inherent human poise is a characteristic of human self-worth that all mankind devours due to their humankind and equivalence. Exclusivity for persons remains the foundation of concerning and cherishing all personalities. The proficient (societal) self-worth is self-worth that can be received by societal communiqué, or it can be vanished, or stimulated. Kalb and O'Conner-Von (2007: 196-202), argued that nursing preparation should guide the learner nurse in the direction of an inclusive consideration of admiration for human self-worth in the CLE, so that they may intermingle with others founded on conducts and performances reliable with hominid self-esteem. According to Parandeh, Khaghanizade, Mohammadi and Mokhtari-Nouri (2016: 1-8) mentioned that if self-worth is preserved, it generates curiosity, inspiration and an optimistic outlook concerning the nursing career, develops proficient associations, effects in suitable decision-making, influence and strong suit, prosperous, proficiency, individual and professional development, self-assurance, encouragement of professional distinctiveness, and specialised healthcare behaviour. This

implies that nursing training should direct the nursing learners toward an absolute perceptive of admiration for human self-worth in both the theoretical and the CLE so that they can be equipped to co-operate with, patients, community members, their colleges and the affiliates of the inter-disciplinary crew efficiently in a respectful manner.

7.7 MAJOR THEME 3: THE FACTORS RELATED TO THE DEVELOPMENT OF HUMAN CARING ATTRIBUTES

The respondents were requested to briefly describe the interior and exterior factors related to the development of the human caring attributes from their perspective. The findings were that the intrinsic factor that plays a major role is: a) primary socialisation whilst for the extrinsic factors the following factors were identified: a) personal experience of the nurses as patients or patients' relatives, b) religious beliefs and cultural background of a nurse, c) inappropriate use of gadgets by nurses, d) peer pressure from other colleagues, e) impact of the rise in the number of social ills in our communities, f) inadequate selection process / wrong career choice, g) lack of support mechanism from nursing management and NEIs management, h) role models' behaviour, i) nurse educators with a negative attitude towards nursing, j) role of the professional nurses and operational managers in student teaching, k) theory-practice gap, l) emotional support for nurses/ student nurses in dealing with negative patient outcomes, m) inadequate involvement of the multi-disciplinary team in nursing students support and guidance, n) image of nurses as perceived by the media and the public and o) nurses' rights versus patients' rights. A narrative of these opinions follows hereunder.

7.7.1 Sub-theme: The intrinsic factors

The primary socialisation

The participants in the study cited that the communities come to nurses because nurses have the expertise to meet the needs of the public that was adopted during the primary socialisation. This study revealed that nurses

come to nursing with certain attributes from primary socialisation especially from: family members, religious and cultural background. The primary socialisation will have a positive or negative effect on the professional socialisation according to the findings of this study. The current study also revealed that the caring ability of the nursing students will be determined by their individuality and the primary socialisation. Primary socialisation plays a major role in how nurses interact or relate to other human beings. The findings of this study also revealed that articulated their opinion regarding the scenario where primary socialisation was not as ideal or good as one would expect. The participants of this study thought it depends, people differ, you will find that in some cases some individuals do change for better, but in some instances, it becomes a bit difficult because most of them you will find that they developed some defence mechanisms or bad habits, and they just covered themselves into a shell that is very difficult to break.

The findings of the current study are congruent with the existing literature. According to Giddens (2009: 1133), socialisation is defined as the societal progression through which youngsters grow consciousness of communal standards and ethics and attain a diverse sense of self. Although primary socialisation progressions are particularly the most important., it continues to some degree throughout life. No human being is resistant to the responses of others around them, which impact and transform their behaviour at all stages of the lifespan. Primary socialisation is defined as the progression by which youngsters study the ethical standards of the general public into which they are born. Primary socialisation happens largely in the family (Giddens 2009: 1129). This implies that all those nurses who had adverse primary socialisation or are experiencing some challenges in their life are identified by their supervisors and through EAP programmes for them to be productive at work.

7.7.2 Sub-theme: The extrinsic factors

The personal experience of the nurses as patients or patients' relatives

The participants in this study also cited that the previous personal experience of the nurses as patients or patients' relatives can shape their caring abilities in a certain way. The current study also revealed that nurses who had a termination of pregnancy spontaneously or by choice might not tolerate the sight of a new-born baby because they might be reminded of that experience; they need to undergo some form of counselling for them to come to terms with their bad experience. The current study also revealed that a nurse who had a bad experience as a patient will change to become a better caregiver following that bad experience because they now have a better insight of how does it feel like to be a patient. The participants in this study raised their concerns about the quality of nursing care received by the loved ones in some public hospitals. Nurses in this study related their experiences to confirm how bad patients' relatives are treated by uncaring attitudes by nurses. The findings of the study also revealed that nurses in the clinical area do not have time to show their concern and support for relatives whose loved ones are terminally ill. This study also revealed that nursing care standards in healthcare facilities have dropped so much that no attention is paid to critically ill patients. Nurse educators use their bad encounters as scenarios in class to caution their learners about the negative attitudes to avoid recurrence.

There is no adequate research found by the researcher on this specific regard. Jooste (2018: 10) argues that the proficient behaviour mentions to some established principles of behaviour that specialists are probable to observe to when expertise and as they deliver their explicit acquaintance and expertise to those who pursue or requires their guidance or assistance. Professional behaviour is established in individual, performances and outlooks; including fundamentals experts' attire and how they achieve their responsibilities. Therefore, healthcare specialists require to perform suitably in a distinguished fashion whether they know the individual in need of their services or not. They are indulged to deliver equivalent care to all the social

affiliates irrespective of their social status or race, colour, or creed. Professionalism formulates the indispensable ethical foundation and point of departure for the healthcare providers' deal with the public and entails of the four features:

- Obligation to amenity.
- Obedience to virtuous morals or ethics (e.g. integrity, beneficence, non-maleficence, justice, honesty, respect for others and compassion).
- Being answerable and accountable.
- Obligation to proficient progression and lifetime book learning.

The religious beliefs and cultural background of a nurse

The current study also revealed that the religious beliefs and cultural background of a nurse also plays a major role in how nurses execute their human caring duties. Some participants stated how their religion commanded them to take good care of each other especially the sick and the poor. The study also revealed that nurses should do unto patients as they would like to see things being done to them or their loved ones. The current study also revealed that at times the cultural background can serve as a hindrance in rendering care to patients especially in the midwifery setting. The study revealed how difficult it is for African male nursing student to observe the deliveries because their culture does not support such an act.

The findings of the current study are congruent with the existing literature. Cultural competency is well-defined as emerging a cognizance of individual's way of life, perceptions, considerations, and atmosphere deprived of permitting it to take an unjustified inspiration on those from other circumstances; indicating information comprehension of the healthcare user's beliefs; accepting and regarding traditional diversity; adapting care to be congruent with the client's values (Flowers 2004: 49). Potgieter and Andrew (2004: 25-26) argued that although some caregivers choose on not to deliver healthcare services to females looking for TOP facilities in civic healthcare centres in KZN grounded on their spiritual associations, spiritual attachments,

on the other hand, inspired caregivers to offer care to accomplish women's healthiness essentials in communal healthcare centres. Dale, Leland and Dale (2013: 1-7) reported that the registered nurses and the clinical instructors in the practice milieu treated learner nurses from various ethno cultural circumstances unethically for no motive. Shaw and Degazon (2008: 44-50) argues that in main culture-congruent interferences is a journey for learner nurses, nurse educators and nurse administrators alike. The bottom line is RESPECT:

- **Recognise** your ethnic principles, heritage, and those of the client without commanding yours.
- **Examine** the client within the perspective of his or her ethnic healthiness and disease performs.
- **Select** interrogations that are not multifaceted, and do not ask queries quickly.
- **Pace** the inquiries throughout the corporeal inspection or the curative session.
- **Encourage** the client to deliberate his or her comprehension of the connotation of healthiness and ailment.
- **Check** whether the client comprehends and admits your commendations and interferences.
- **Touch** the client with compassion, displaying admiration for ethnic limits. Etiquettes are significant for nurse- patient association.

Therefore, this implies that the negative attitude and behaviour of nurses, whether due to religious and cultural beliefs in the working environment in South Africa, the variety of principles is embraced are in direct contrast with the constitution of our country and the nurses' ethical legal framework. Caregivers irrespective of their specialised rank are supposed to have cultural competence that will enhance the communication with the patients,

community members, their colleagues including the affiliates of the multi-disciplinary team. Nurses and doctors have a privilege to negotiate their work allocation with their supervisors if they choose not to participate in some activities they should be allowed to exercise their rights.

The inappropriate use of gadgets by nurses

Entirely, the respondents in the present scholarship were disturbed about how nurses misuse their cell phones while they are on duty. The participants in the current study inappropriate use of gadgets by nurses were also cited as one of the instrumental aspects to subservient nursing care. According to the participants in the current study, nurses listen to their conversations on their cell phones while on duty or use their cell phones to post patients pictures without their concern, so then the patient care suffers as a result.

The discoveries of the present investigation approve the conclusions of other researchers. The Bill of Rights in chapter 2 of the constitution of South Africa approves the autonomous morals of human self-esteem, impartiality and self-determination. The privileges appropriate in this perspective are the privileges to (i) have self-worth secured and valued, (ii) corporeal and mental veracity, (iii) egalitarianism, (iv) confidentiality and (v) self-determination of communication. Kubheka (2017: 388) argues that experts must do introspection preceding stationing on societal mass media whether distributing particular info is legitimately and ethically defensible, whether it mirrors the proficient behaviour predictable of them and whether it will profit their clients, and significantly interrogate their intention for posting. Present medicinal preparation comprises teaching on communiqué expertise, nonetheless, it does not deal with the profits and dangers of computerisation of announcement, specifically on societal mass media. HPCSA and SANC desire to cultivate social media recommendations and teach the health trainees in this specific capacity. Health care institutions must advance social media policies and acquaint their operational personnel regardless of their proficient designation or qualification. While social media has simplified

communication and consultation amongst for professionals, it has the probability to undermine patients' rights, challenge proficient, and proprietor associations if its usage by specialists is not channelled. This author argues that societal broadcasting is not wicked, but the intents of experts and in what manner they usage such podiums might direct to unethical or illegitimate activities defensible (Kubheka 2017: 388). This indicates that the use of communal mass media by all the personnel on duty desires to be scrutinised and directed through guidelines by all the professional bodies and the employer.

The peer pressure from other colleagues

This decline in the standard of the nursing care was also linked to the peer influence according to the respondents in the current investigation. This study also revealed that peer teaching also contributes a substantial duty in mentoring and supporting the nurse on training. Nursing students learn better when they are being mentored by other senior students in the wards. The discoveries of the present scholarship are in-contrast with the existing literature. The existing literature addresses peer support rather than peer pressure. Peer support is described as a group of pre-registration nursing students learning from each other (Roberts 2008: 367-371). The aforementioned researcher maintains that patrician backing in the CLE is often disregarded, is a vital element in enabling learner nurses' learning. Her findings reveal that students' associations are significant for knowledge acquisition. Learners backing for each other, deliberate them perform, part acquaintance, expertise and encounters, thus being mingled in the occupation. Learner nurses working together share encounters, backing each other, and deliberate on challenges and matters about practising together (Bourgeois, Drayton, and Brown 2011: 114-118). Absence of aristocrat backing in the CLE is demonstrated by clashes, pressures and opposition for chances for performs which is harmful for erudition (Chuan and Barnett 2012a: 192-197). The significance of peer support and administration should be measured and integrated when designing clinical learning. Pressures and

apprehensions are lessened in a practice milieu where learners are welcoming towards each other (Roberts 2009: 367-371).

The impact of the rise in the number of social ills in our communities

Participants in this study articulated the issue about the rise in the number of social ills, so according to them our recruits are going to behave likewise because that is the only thing they understand. This study also revealed that parents are too busy doing their work, as a result, their children end up not learning how to communicate properly. The parental role of grooming the young ones has been taken over by social media and gadgets. This study also revealed that parents need to use the limited time they spent with their children by teaching them how to communicate properly and expressing their love and concern for them.

Inadequate selection process / wrong career choice

The current revealed that nurses are not happy about the way recruitments and the selection for training is conducted for nurses are conducted nowadays. There were concerns raised regarding the selection for training is done online, basing it on the matric grades only without interviews. The reduction in the number of students for training in the government institutions was also raised by the participants in this study. According to the participants in this study, some people came to nursing not having enough knowledge about what does the nursing profession is all about. This study also revealed that some nursing students who came to nursing not because they had a passion for it, but because of some compelling reasons; they find it difficult to do their work compassionately. The study also revealed that those nursing students, nursing was not their first choice but they ended up doing it so they will find it difficult to be caring nurses. Surprisingly, most nursing students who did not love the nursing profession but after being exposed to the theory of nursing they ended up liking the nursing profession and become good nurses, and this was attributed to the subject Ethos of Nursing and the Professional Practice. Ironically nurse educators in this study thought that the behaviour of

the learners who had previously enrolled in other courses is very difficult to mould because they think that they know it all. The study also revealed that stipend was cited by the participants as one factor that attracts most people to join the nursing profession, ironically the amount of the stipend also made some nursing students leave the nursing profession. The high unemployment rates of graduates contribute towards the attraction of the wrong recruits who do not have a passion for the profession, but because they come to nursing because they meet the training requirements.

The findings of this study are congruent with the existing literature. The findings of the current study affirm that of van Wyngaarden (2017: 153-154) who argues that learner nurses' selection process was insufficient because nursing students chosen were not fascinated about nursing career and are only in it for the stipend or for using nursing profession to further their career in other areas. This author argued that the assortment procedure needs reconsideration to choose learners that show characteristics such as understanding, consideration and kind heartedness. Armstrong and Rispel (2015: 7) stated that recruitment and selection of potential learner nurses justify for some of the difficulties encountered in the nursing profession nowadays. Hubbard (2015: e3) contends that a robust incident contrary to using only interviews as a particular conclusive element for choice, qualities such as veracity, compassion and team cognizance requires to be ridiculed and considered as well. Therefore, there is a need to revisit the selection process paying more attention to the following attributes: caring, passion and empathy should be considered as a pre-requisite for all the nursing recruits.

Caring for the nurses and the nursing students

The outcomes of the present scholarship also revealed that learner nurses find it easy to care for the patients when their lecturers show them that they also care for them. One participant who was involved in a smash and grab related how supportive her lecturers were during that time of despair and frustration. That made manage to show the authentic reaction to them

because she felt like her mother was there for her. She felt special. After, the lecturers showed care for their learner it made her realised that she is not just a number to her lecturers but she is also important. The study also revealed that students who feel cared for by the nursing faculty also become good caregiver for the patients. The current study also revealed that the psychological and the emotional aspect of the nursing students need to be taken into account by their lecturers/ clinical facilitators when teaching nursing students how to care for others. Actions should tell that they are being cared for, for these neophytes to demonstrate care to their patients. The current study also articulated that when students have experienced negativism during your training as a student or maybe the nursing student was ill-treated by their lecturers or seniors in the clinical area during their training there is a high likelihood that they also ill-treat their junior nurses or nursing students when they are qualified or treat them bad as that is the only thing they know. This study also revealed that nurses are taught about holistic care for patients, but when it comes to them they are told to leave their problems at the gate and take them with when they knock off according to the respondents in the present investigation. The scholar nurses need to feel cared for by their lecturers for them to be enabled to show consideration to the care receivers.

The discoveries of the present schoolwork concur with the study done by Jooste (2018: 25-26), argues that the nursing profession originated because of the compassionate desires for others. To be a caring person, one has to distinguish that the necessities of others often take superiority over the necessities of the self. Nevertheless, a caring the caregiver also discovers her or his necessities required to be gratified allow her or him to accomplish the compassionate duty. The art of this lies in the understated complementary of gratifying one's caring requirements and satisfying the caring desires of clients (Jooste 2018: 25-26). Tiwaken, Caranto and David (2015: 70) and Borrageiro (2014: 20) affirm that learner nurse that received the clinical supervision and guidance from the instructor who assisted them with the experimental duty and considered their feelings. Registered carers in the CLE must be optimistic starring role replicas and be exemplary to learner nurses

(Bruce *et al.* 2011: 257). Gumabay (2017: 91) argues that learner nurses have mutual opinions on the compassionate performances of the NEI: that these considerate accomplishments are efficient in improving the association of amongst learner nurses and their NEI. The aforementioned author concludes that NEI associates have not only proficient features but also, individual features intrinsic and predictable of a counsellor. While, assumed appropriate induction, consideration, and info by the NEI, the learner nurses are made to consume confidence, self-trust in implementation in totality, relationally, and cultural diversity while on the connected learning experience. The aforementioned investigator determines that excellence associated learning experience of learner nurses with the supervision from the NEI makes the learners good carers in their future (Gumabay 2017: 91).

According to Watson's Caritas process, four deliberations of situational issues have input to the institution of reliance. Nurse educators state that the inflexible guiding principle that is applied when learner nurse is having a serious problem or who is bereaved warrants to be reviewed. Watson's Caritas process 3 affirms that expressive agony necessitates similar devotion as the somatic agony. In contrast, some participants in the present study believed that nurses' mental aspect is as important as professional competency, but little to no attention was paid by nurse managers and nurse educators in that regard. It is not a common practice for nurse managers to enquire nurses about how they feel unless they are obvious clues such as crying. In some cases, nurses were told by their superiors to leave their problems at the gate. Whilst in some cases respondents were impressed about the backing they obtain from their superiors when they are encountering challenges. This implies that for caregivers (irrespective of their professional rank or position) to be able to render holistic care to the patients they also need to receive holistic wellness need to be taken into consideration by their superiors.

Role models' behaviour

The current study revealed that nursing students look at their lecturers as their role models. The current study revealed that nurse educators should be mindful how they address their students because if students are addressed anyhow they will also address other people like that. This investigation also discovered that learner nurses do not only look up to their lecturers for role models, but they also copy the behaviour of their seniors and co-workers in the clinical placement. This study also revealed that well-groomed nursing student can also learn bad character from the clinical learning environment. Nursing students tend to copy negative attitudes and the short cut way of performing the nursing skills from fellow nurses in the clinical area because that is what they see on a daily basis. Respondents in the present research stated that what one learned from the people one admired takes very long in one's mind. Neophytes are more dependent on the professional nurses from both theory and clinical when they are teaching you all these skills, you will still remember even their names on a later stage. Respondents also cited that some nurse educators could instil negativity about the nursing profession to the students. Learner nurses do not only copy the negative behaviour from their role models, but the professional or unprofessional image as well according to the respondents in this study.

Findings of the present research are congruent with the existing literature. The study conducted by van Wyngaarden (2017: 148), revealed that qualified nurses are not role models, if specialised caregivers fail to fulfil the part of a role model to learner nurses, the aforementioned are indeed unprotected to uncaring performance in the practice milieu and that may severely wound their scholarship and the forthcoming functioning encounter. This author further interrogated the conduct of the registered carers and considered them as requiring in qualities such as compassion and desire for the career. Kgafela (2013: 103) and de Swardt (2013: 103) argue that starring role demonstrating by qualified caregivers is viewed as extremely significant since learners reproduce and study from them. Braz, Memarian, and Vanaki (2015:

8) cited that qualified nurses have to supervise and monitor learners through efficient communiqué and the providing of psychosocial optimistic learning surroundings.

Nurse educators with a negative attitude towards nursing

The current study also revealed that some nurse educators speak negatively of the tending career. Respondents of the present research articulated that the problem with those lecturers started there it was not their intentions to become a nurse and they carried that until they became nurse lecturers. The participants also articulated that, nurse educators who had experienced negativism during the training where their lecturers or senior nurses had been implanting to them that they are nothing they are going to fail and all those negative things you will find that they transfer that negative attitudes to the neophytes. The nurse educators in this study also revealed that those lecturers who experienced difficulties during their training also give their students difficult times.

The discoveries of the present scholarship are congruent with the existing literature. Van Wyngaarden (2017: 145), recognised that the necessity for the operational collection of facilitators with both the practical and the theoretical exposure. This author also highlighted that nurse educators are not enthusiastic about education and are performing it perhaps for the fixed periods and remuneration. This author also cited that the apparent lack of caring emphasised, uncaring instructors will impact learners thus generating a malicious circle of uncaring performance. The kind heartedness and compassionate facilitators go the extra mile and exhibit the state of being good examples in their coaching and conducts towards scholars and care receivers. Killam and Heerschap (2013: 687) affirm that if instructors “just do it for the money and they are not interested” scholarship sustains the negative outcome. Kunnari and Llomaki (2016: 167) recognised instructor’s inspiration and eagerness as contributing factors of varying coaching performs within HEIs. This implies that to recover the excellence client compassion, there is a

requirement to break this vicious cycle of uncaring, uncompassionate nurses regardless of their professional rank. There is a need for the Department of Health and all the professional organisations to converge and co-operate in trying to revive or restore the quality patient care that is evidenced by positive patient outcomes.

The role of professional nurses and operational managers in student teaching

The participants in this study cited their concerns about the reluctance of the professional nurses to play their role in applying discipline to the nursing students. Operational managers would rather tell the nursing students that nurse educators compel them to discipline them. According to the participants in this study, some permanent staff also displays some negative attitudes towards the patients in the wards. The current study also revealed that these days you find three or four nurses versus twenty-seven or more patients and they are still expected to transport patients out of the ward and accompany patients to x-rays and also do the ward routine. The present research also has shown that the learner nurses are well prepared emotionally and had compassion for the nursing profession will end up adopting the wrong behaviour by the professional nurses in the CLEs. Professional nurses in the wards do believe that nurse educators are not knowledgeable regarding the nursing procedures according to respondents in this research. The participants in the current investigation also revealed that professional nurses forget that they have a responsibility to mentor and guide the nursing learners. Lack of adequate human resources in the CLE was also blamed for compelling nursing staff to resort to the short cut way of doing nursing procedures according to the participants in the present study. Current research also displayed that the unit managers disregarded learners' level of training and the learning outcomes when allocating duties to them in the clinical placement. The respondents in the present research believed that nurses need to uphold the professional norms and standards very high in their value system. The present research also displayed that nurses must not

impose their religious values on the patients. Nursing students like copying the procedures that are done by the professional nurses in the wards regardless of what they were taught at the NEI's according to the participants in this study. The nursing students observe professional nurses fighting each other and bad-mouthing each other in the wards according to the respondents in the present investigation. Some respondents in the present research cited that substance abuse is the reason why some professional nurses misbehave at work.

The discoveries of the present study are congruent with the findings of the existing literature. Lekhuleni *et al.* (2004: 18) argued that the accountability of a qualified caregiver in the clinical milieu is to execute nursing procedures adhering to established values, specifically when learners are in the CLE so that they acquire the correct manner of performing those nursing procedures. Nursing students must be supported and rectified if they do errors while emerging from reliance to self-reliance, to be given constructive criticism in front of everyone and for them not to feel humiliated (Lekhuleni *et al.* 2004: 18). Tshabalala (2011: 40) affirms that the bulk of qualified carers demonstrated an undesirable approach in the direction of learner nurses. Whilst Nasrin *et al.* (2012: 1-7) argues that qualified carers in the practice milieu did not admire patients' privileges and therefore discouraged learner nurses. Sinclair (2013: 66-68) found that qualified carers were not dependable and the facilitators and professional nurses "bullied" learner carers. This implies that the way qualified nurses to interact with patients should be ethical and according to the set norms and standard to facilitate student learning.

The theory-practice gap

Respondents in the present research argued that the deficiency of human and material assets in the CLE leads to the theoretical practise opening. The learner nurses in the current investigation argued that they were sent to the ward to do a specific part of their training outcomes because when they come to campus they were taught specific part of theory; then they were expected

to practise that in the wards, but they do not get time to do that, because nursing students are now regarded as part of the workforce. The nurse educators in this study also shared sentiments with their students regarding the abuse of nursing learners in the clinical area due to the shortage of human resources, which end up being students' burden according to them. The respondents in this investigation also argued that the learner carers that are joining the nursing profession these days are more brilliant than them, but the system and prevailing circumstances are putting them down because by overburdening them as evidenced by second-year nursing students were left all by themselves to run a 52 bedded wards. The current study also revealed that the lack of necessary resources negatively affects the practice of skills and procedures in the clinical area, and consequently the quality of nursing care is compromised. Respondents in the present research stated that nurses in the clinical area end up improvising by destroying what they have at hand to provide the service for the patients e.g. cutting patients pyjamas to improvise for face towels, and doing the procedure wrongly when you know very well what will be consequences on the patient makes nurses feel very frustrated.

The current study also revealed that the lack of basic resources could be more evidenced during the students' assessments according to participants in this study; to an extent that students are required to use their monies to purchase some basic equipment for their assessments. The study also revealed that carers do not spend period to converse with healthcare users as expected due to the alarming shortage of human resources and that compromises the quality of care according to for example some patients are sent to theatre not having clear information regarding the procedure that is going to be done to them. Surprisingly, the respondents in the present research argued that the severity of the scarcity of resources differs with the health institutions, even if all those are government institutions. The discoveries of the present study also discovered that the caregiver-patient ratio per shift is the reason for the decline of the human caring in some healthcare institutions; it forces some nursing staff to perform some

procedures that are not within their scope of practice just for the benefit of the patients. The respondents in this investigation revealed that learner nurses are sometimes moved from the wards where they are allocated to cover up for the shortage in another ward where a staff member is absent. The learner nurses are sometimes asked by their lecturers to buy the necessary equipment for them to perform the nursing procedures the correct way. The nurse educators in this study also shared sentiments with their students regarding the abuse of nursing learners in the clinical area due to the shortage of human resources, which end up being students' burden according to them. The participants in this study also argued that the nursing students that are joining the nursing profession these days are more brilliant than them, but the system and prevailing circumstances are putting them down because by overburdening them; as evidenced by second-year nursing students were left all by themselves to run a 52 bedded wards.

The credited experimental services must have sufficient experimental assets for learners to accomplish their experimental erudition result as prescribed in their curriculum (SANC 2013c: section 58(1) (g). D'Souza *et al.* (2013: 30) argues that when learner nurses receive backing from multi-dimensional resources at the CLE their contribution is adequate. These funds comprise human assets, experimental apparatus, materials, archives and others. Mampunge and Seekoe (2014: 58-66) cited that at the CLE there was neither laptops nor archives to be utilised by nursing students. Killam and Carter (2010: 1523-1528) affirms that nursing students do not have accessibility to technology and other assets such as a reading room in the CLE. These authors also cited that the demonstration of skills by nurse educators at the clinical learning environment was affected negatively by the use of outdated equipment and a shortage of supplies. Naranjee (2012: 39) reported that nurses failed to perform procedures according to the way they have been taught, because of the scarcity of apparatus and materials at the CLE. Sinclair (2013: 63) established that clinical practice milieus were hazardous and the healthiness provision was at jeopardy as a result of scarcity of the experimental assets. The findings of the present study also correspond with

Kgafela (2013: 122) who stated that as a result of scarcity of apparatus in the CLE, some scholar carers were utilising their apparatus to ensure appropriate consumer compassion; whilst in the current study, nurse educators had to ask their students to buy equipment using their own money for the purposes of the assessment. Efficient supervision and guidance are fundamental in safeguarding proficiency of recently trained professional carers (Morolong and Chabeli 2005: 38). Therefore, the accompaniment of the newly graduated professional nurses is very crucial, since they are expected to guide and mentor those still on training. The researcher has observed that usually, the incompetent or unknowledgeable professional nurse is likely to respond with a negative attitude towards the inquisitive learner because they might end up exposing their incompetence. These findings reveal that the accessibility and inaccessibility of assets in the CLE performs a foremost role in the achievement of the clinical learning objective of the nurse learners, the accompaniment of the nursing students as well as the patient outcome.

Emotional support for nurses'/ student nurses in dealing with negative patient outcomes

This study also revealed how the lack of necessary resources and supplies influence adversely on the patient outcome. The student caregivers are faced with the challenge of the shortage of staff and equipment, dealing with the negative patient outcome because of the unconducive working conditions, adds another emotional strain on the nurses on training according to contributors in the present scholarship. The present investigation also revealed that coaching scholar nurses how to demonstrate kind heartedness is not easy for instructors due to the lack of supplies and material. Educators raised their concern about the issue of the setting of double standards, they related that at the college nursing students were taught about the importance of observing the principles of the infection control, but in the ward, the students are asked by professional nurses to tell the patients to bring a blanket from home because there are no blankets in the hospital.

The nurse educators were concerned that those are the factors that contribute to poor nursing care. Nurse educators are teaching the nursing students something else in the wards professional nurses are doing something else. Another concern raised by the nurse educators was about the change of patients' linen, which was not happening as required because there is no linen in the hospital. The study also revealed that nurses' shortage in the wards is so severe that some nurses wish to replicate themselves into many bodies to cope with the workload. The nurse educators in this study also shared sentiments with their students regarding the abuse of nursing learners in the clinical area due to the shortage of human resources, which end up being students' burden according to them.

The study also revealed that prevention of cross-infection was also raised as a challenge according to the nurse managers, due to the lack of adequate infrastructure in the wards. Nurse managers cited that, if one patient who was isolated is discharged or passed on there is no time to clean and fumigate the sideward before admitting the next patient, and then they are transferring infection from one patient to another; because they have no choices and they are not sure whether the patient will be diagnosed with TB, MDR or XDR up until we have results. The current study revealed that nurses need support from the employer/ management and other staff members with more experience in the field. According to nurses in this study, experiences that nurses come across during the performance of their duty leave nurses devastated and frustrated. It depends on the type of the ward where the nurse is allocated; some wards were classified as stress-provoking according to the contributors in the present investigation. According to contributors to this research, nurses react differently to stressful events. According to the participants in this investigation, some public hospitals in this province do provide counselling and emotional support to their staff members. Nurses need to be taught how to separate their personal life from their work according to the respondents in this reading. Operational managers in the present scholarship nursing area managers are not always available to support the operational managers in the wards. Contributors in this scholarship

mentorship perform a vital responsibility irrespective of the position that you occupy in the hierarchy. Facilitators cited that student nurses are unable to relate their life issues to their lecturers if they are not approachable. The lectures need to avail themselves for the nursing students who need to consult them for any reason.

Gilmour *et al.* (2007: 5) describes advising as an advising association in which the counsellor and one being counselled are alike to concerning oldness and/or rank. These researchers also showed that it is this patrician counselling where elder learner nurses familiarize low-grade learner nurses into different experimental surroundings, giving the low-grade nursing students with backing to the degree that an individual being counselled attest diminished apprehension in the course of fine-tuning in the experimental drill. These discoveries are armor-plated by Allen (2002: 440) in pronouncing that aristocrat-to-aristocrat guiding was established to be supplementary operational and prevalent associated with counselling by other well-known counsellors. These writers are also sustained by numerous other investigators who established that aristocrat counselling associations are imperative intending career and concerning these interactions as coaching the worth of collegial loyalty amongst older and subordinate learner nurses, thus decreasing fatigue on the student nurses (Bryne and Keefe 2002: 394; Riley and Fearing 2009: 230). Therefore, this implies that emotional support and mentoring for the nurses regardless of their ranks needs mentoring and debriefing when necessary.

The inadequate involvement of the multi-disciplinary team in nursing students support and guidance

Nursing carers in the present investigation mentioned that they are not taught during the ward rounds in the CLE. The learners were deprived of the learning moment because things might happen in the ward whilst they are busy taking the patient to x-rays department, and they will miss out on those learning experiences e.g. if there can be a resuscitation of a patient going on. Nurse

educators in the current study raised their concerns saying that the doctors' rounds are no longer done the correct way in the practice environment these days due to the scarcity of personnel.

The associates of the multi-disciplinary crew comprise all healthiness experts functioning in a healthiness atmosphere with a communal goalmouth of reinstating the customary existence of persons (Bonnell 2009: 456). Discoveries of the present scholarship are dissimilar with the investigation completed by DuToit (2013: 56) in the North-Western Province, undergraduates had optimistic involvement when functioning with physicians, where they pronounced that physicians were extra supportive than tending staffs. Similarly, in the investigation completed by Kgafela (2013: 108-109) in Gauteng Province undergraduates were getting supervision and backing from physicians and division administrators. This investigator cited that the affiliates of the multi-disciplinary crew might augment to the scholarship milieu on condition that the operational administrator has clarified the philosophy of the tending ward in relative to knowledge acquisition. While in research completed by Mlek (2011: 98) in Canada, stated that undergraduates had technical hitches and traumatic affiliation with the doctors, as they were not appreciating the views of undergraduates for the reason that the aforementioned were short of expertise and information.

In the study done by Awuah-Peasah, Akuamoah Sarfo and Asamoah (2013: 24-25) in Ghana stated that nursing students were not interrelating with physicians to display curiosity in experimental scholarship throughout universal doctors' rounds. The discoveries of this research are corresponding with the discoveries of Sibiya and Sibiya (2014: 1943-1958) who stated, that experimental personnel were not keen to oversee and monitor undergraduates for the reason that personnel are scarce. Therefore, affiliates of the multidisciplinary team must be intricate in the coaching and direction of the undergraduates. It is significant for the undergraduates to display enthusiasm and a positive attitude towards education. During the orientation of the multi-disciplinary team members in each ward, the operational manager

should state categorically the importance of nursing student teaching and guidance in her unit.

The image of nurses as perceived by the media and the public

The present study revealed the findings that the adverse promotional about the tending career in the broadcasting serves as a discouragement to committed nurses. The nurses in the current study believed that media should get both sides of the story right before going public about any negative incidences. Some nurses in the current study wish that the public can see things through the nurses' eye. The participants in the current study cited that some patients and the community members do not communicate well with the nurses. Ironically, some few patients do appreciate what nurses do for them conferring to the contributors in the present investigation. Carers should have emotional intelligence and should be able to let go of patients or relatives' unacceptable behaviour towards them, because sometimes when relatives have a family member who is approaching death tends taking out their frustration on nurses. Media and the public image of nurses are so bad. They perceive nurses as non-caring because they are not told the real reasons about the prevailing circumstances in the healthcare environments.

The discoveries of the existing research are consistent with the findings of the existing literature. Waters (2005: 22) cited that the public status of carers and tending career is fundamental for the efficacious employment and retaining of carers, a necessity for the provision of excellence kind-heartedness to South African citizens. Hosken (2009: 1) mentioned that adverse publicity might dramatize challenging proceedings, such as undesirable encounters of healthcare users and their relatives. Whilst, Nelson and Gordon 2006: 13) the underprivileged professional appearance as depicted by the broadcasting, may encourage youth not to contemplate tending as a vocation choice on nursing might influence the public's perception (Nelson and Gordon 2006: 13). Beauregard, Richardson, Deck, Rose, Kay, Silver, Haynes, White, Inman, George and Perry (2003: 510) argue that the South African community

appeared to assess characteristics of tending career adversely. Morris-Thompson, Sheperd, Plata Ba and Maran (2011: 683-692) cited that the community seems not to be well-versed of what caregivers perform. The contribution of caregivers in cultivating the community information about the nursing occupation and the miscellaneous and operational duties of carers in the healthcare organisation using broadcasting as a technique to repair the community opinion of carers (Varaei, Jasper and Faghihzhadeh 2012: 559). The accountability to transform these views ought to be a precedence for caregiver front-runners. Carers have to partake in proficient and public associations to encourage their undertakings to expand the distinguishability of carers and the career (Beauregard *et al.* 2003: 510). This implies that nurses should work harder to revive the professional image.

The nurses' rights versus patients' rights

The current study revealed that nurses were concerned about the government who is paying more attention to patients' rights versus healthcare workers' rights. Surprisingly according to the nurse managers in the current study also raised their concerns about how the nurses over-emphasised their rights over patients' rights. Operational managers in the study also cited their concerns it is difficult to apply disciplinary measures on the nurse these days. They also related their challenges regarding the issue of the nursing students' refusal to work after hours and over the weekend. The current study also revealed that nurse lecturers cited their opinion about the importance of emphasising religious practice during the primary socialisation and automatically improving the human caring attributes.

The discoveries of the present research are consistent with Awuah-Peasah *et al.* (2013: 26) who mentioned that the bulk of the undergraduates have a habit of reporting late for work. These authors further stated that preponderance of the learners did not report on duty for their experiential exposure and fail to send reports about their whereabouts. The experimental training is similarly significant as theoretical learning. In addition, the CLE offers the essential

real-world expertise that undergraduates require to assist them in their forthcoming undertakings as knowledgeable and proficient caregivers (Awuah-Peasah *et al.* 2013: 26). According to Jooste (2018: 247-248), client well-being and excellence of consideration are an everyday apprehension for healthcare specialists due to increased knowledge of health matters on the part of clients. In South Africa, the introduction of the Bathopele Principles has also placed greater emphasis on clients' rights. Experimental frontrunners for that reason must ensure that a range of expertise and interpositions are articulated, that they may utilise to stimulate and engross experimental crews in danger valuation and incessant excellence enhancement at all levels of client care provision. Clinical leaders should be engaged in the observation of the care given to clients and focus on unceasingly refining the well-being and excellence of their operational milieu and the consideration provided to clients within that setting (Jooste 2018: 247-248). Therefore, educational institutions, practising nurses, and nurse managers must collaborate in applying the corrective measures to ill-disciplined learners to mould their behaviours before registration as professional nurses.

7.8 MAJOR THEME 4: THE EXPERIENCES RELATED TO THE DEVELOPMENT OF THE HUMAN CARING ATTRIBUTES

The respondents were requested to relate their theoretical and clinical encounters that resulted in the development of the human caring attributes in their perspectives. The findings were that a) theoretical learning experiences and b) the clinical learning experiences-opportunity to practise caring. The description of these perceptions follows hereunder:

7.8.1 The theoretical experiences

The present study revealed that nursing students commended the social science component of their theory for assisting them to understand other people's cultures better. Nurse Managers in the current study cited that there is a need to put more emphasis on ethics and professionalism during theoretical teaching or the neophytes to master the nursing culture and ethical

behaviour. Theory exposure resulted in gaining the understanding of cultural diversity according to the respondents in the present investigation. According to the nurse educators in the present research carers are trained about the importance of caring in the nursing profession. Nursing students are also assessed during the clinical assessment if they can incorporate caring during their interaction with the patient. The results of the present investigation revealed that nurse educators stated that nurses' pledge of service is an important tool to remind the nursing students about caring. Learner nurses in the present investigation the effort that their lecturer put towards teaching them the theory is commendable. According to the participants in this study, nurse educators were not only commended for the doing a good job in teaching nursing students but also they were commended for supporting them and telling them not to allow the prevailing circumstances in the clinical area to transform them.

The discoveries of the current investigation are congruent with the existing body of knowledge. According to Lombardi (2007a: 2) and Parker and Maddox (2015: 14), authentic learning is learning that places emphasis on real-life, challenging, complex and ill-defined problems and their unique best solutions. It embraces methods such as clinical conferences, problem-based activities, community outreach projects and participation in virtual communities of practice (Lombardi 2007a: 2 and Parker and Maddox 2015: 14). The significance of tending instruction in the development of learner nurses' intellectual capacity with the ability to create, reflect, analyse, transform information, solve complex problems, make rational decisions and promote lifelong learning (Council on Higher Education (CHE) 2014, January, Department of Health (DoH) 2006, Ministry of Education 2001 and the South African Nursing Council (SANC) 1992a. Huang (2011: 565) argues that nursing students must be developed into resourceful nurse practitioners that are capable to act on their accrued information and expertise intellectually by adapting and applying it to new, unfamiliar contexts to care for their clients safely, effectively and appropriately. However, this nursing education goal may prove to be difficult to attain since higher education is characterised by

decontextualized and abstract teaching that forces nursing students to acquire superficial, atomistic learning. Whilst Brown and Mevs (2012: 4) argues that authentic learning is a learning approach that engages learner nurses in the interactive, integrated, multi-disciplinary problematic resolving, making decisions and precarious intellectual utilised by experts in their everyday lives. This implies that it is pivotal for all the nursing education stakeholders to work collaboratively to ensure that the end product acquires all the afore-mentioned skills and competencies.

7.8.2 The clinical learning experiences-opportunity to practise caring

The environment in which this human interaction takes place is very important for it to be successful according to participants in the present investigation. Nurse learners in the current research articulated that they experience challenges with the integration of the theory into practice. Those difficulties were ascribed to the information that during demonstrations at the NEI's instructors are using gimmicks, but in the CLE there are real patients; so the student gets overwhelmed and frustrated in the absence of their clinical facilitators from the college. Nursing students are taught how to put an IV line using a gimmick for the first time because you have to know your veins and arteries and when they have to do it on an actual human being; when they try to puncture the vein patients jump and some of the reactions they get from patients are things nursing students did not expect so they do not know how to deal with them.

Nurse educators also share sentiments with their students in regard to nursing students encountering challenges when they try to integrate the theory into practice. Nurse educators articulated that, due to shortage of staff nursing students do not find themselves being students in the clinical learning environment to practise whatever they have learned, but they find themselves filling in the gaps of permanent staff. The contributors in the present investigation the scarcity of assets in some public hospitals makes it hard for nurses to do their work. In public hospitals, the environment is not very

conducive to the development of human caring attributes. There is a lack of resources both human and equipment. There is a lack or shortage of bed linen, for instance, it is winter now and there are no blankets for patients. The lack of material and human resources was attributed to mismanagement by the DoH. The aforementioned organisation is failing to manage the public health as they are expected and they are not distributing their resources fairly, because with some public hospitals things are extremely bad. The shortage of staff is also worse there is always one professional nurse per shift in a forty bedded ward. One enrolled nurse and also one enrolled nursing assistant per shift that is not enough. It becomes better when nursing students are there but they end up being used as a workforce rather than nursing learners and they are not supervised.

The discoveries of the current investigation are congruent with the prevailing body of knowledge. Ali, Banan and Seraty (2015: 5) affirmed that for knowledge acquisition to occur, the practice milieu must be favourable for a scholarship. Practice environment that is favourable to scholarship have instructors who think through undergraduates' emotional state and try by all means to support scholar carers who consecutively anticipate approaching to the experiential learning milieu, and prudently premeditated distribution of experimental duties in the unit (Ali *et al.* 2015: 5). According to Meyer *et al.* (2011: 112), trials which institute a practice environment favourable for scholarship comprise: undergraduates being intricate as crew affiliates, backing and channelled by experimental personnel; exemplar perception, response about their demonstration being given at systematic intermissions; scholarship occasions and scholarship assistances obtainable, and learners must be allowed to enquire.

7.8.3 The student nurses' role in the clinical placement

The outcomes of the present investigation exposed that are not educated by the unit administrators and the qualified caregivers in the CLE. There are no planned teaching programmes in the wards. Students are sent to run errands

in the wards, they are used to cover up for any rank or staff category from a porter, cleaner, nursing assistant, enrolled nurse and professional nurse for senior students. Sometimes nursing students are used to accompanying patients to different departments during the clinical placement. Fourth-year students are regarded as professional nurses and are given too much responsibility e.g. of running the ward, as a result, they feel overwhelmed at times. According to the participants, nursing students do not only fill the gaps for the permanent nursing staff, but they also serve as messengers and porters as well. The current study also revealed that some professional nurses disregard the nursing students' level of study or their outcomes but use them as messengers or porters. Finalist students are sent as messengers and that was perceived by the nursing students as undermining them. This study also revealed that operational managers do not take advantage of the days and times when the ward is quieter to teach their staff e.g. weekends. For undergraduates, it is challenging to handle the work-load in the wards due to serious scarcity of staff. Facilitators in the present research argued that senior nursing students are forced to do basic nursing care in the wards due to the shortage of caregivers.

The discoveries of the current research are in contrast with the available body of knowledge. SANC (2013), state that when learners are undertaking drill; their rank must be that of complete learners as an alternative of having a dual status of being a learner and an employee in the CLE. The current study confirms the findings of Sengstock (2009: 93-94), which stated that undergraduates' responsibility was not obvious as they were regarded as unpaid workers, additional physques on the ground or volunteers. Tabriz, India, Rahmani, Zadeh, Abdullah-Zadeh, Lotfi, Bani and Hassanpour (2011: 253-256) argued that the minute nursing students were placed in the practice milieu their experimental tasks were indistinguishable. Contrary Rani, Brennan and Timmons (2011: 17), conducted a study in a special forensic mental health setting and reported that nursing students were treated well and were satisfied with their experimental learning exposure. Findings of the present investigation also concurred with that of Killam and Carter (2010: 8),

Mogale (2011: 68), Kgafele *et al.* (2015: 236), Letswalo and Peu (2015: 357), Karabulut, Aktas, and Alemdar (2015: 12), Dale *et al.* (2013: 1-7) and Motsilanyane (2015: 79) stated that learner nurses were regarded as employees in the clinical learning areas. Volschenk (2009: 7) stated that it was not easy to extract nursing students from the ward when the clinical facilitator was around for accompaniment or assessment purposes. Therefore, nursing learners should be regarded as learners in the experimental placement milieu, failing which necessary steps should be taken by the accrediting body.

7.9 MAJOR THEME 5: THE WORKING ENVIRONMENT AND THE DEVELOPMENT OF HUMAN CARING ATTRIBUTES

The respondents in this investigation were questioned about their viewpoint regarding the clinical working environment and the development of the human caring attributes. The findings were that: a) un-conducive working conditions, b) low staff morale and c) the hospital management issues. A description of these perceptions follows hereunder.

7.9.1 Un-conducive working conditions

The discoveries of this investigation discovered that the clinical working environment was perceived by nursing students, nurse educators as well as nurse managers as unfavourable for the development of the human caring attributes. They based their arguments on the fact that undergraduates were not treated as nursing students; due to the alarming scarcity of human and supplies. They also cited the fact that the nurse-patient ratio was so abnormal. This investigation also discovered that the nursing students end up not learning anything but working as the workforce in the wards. The present research also exposed that senior undergraduates feared that they would not be competent enough when they are qualified as professional nurses, because they never had an opportunity to practice nursing administration during training. They only focused on basic nursing care, since there was also an extraordinary percentage of absence amid the eternal personnel. The current study also revealed that nurses were tired of explaining themselves to

patients about the reasons for not being able to carry out certain procedures due to shortage of equipment and supplies in the wards. In the present research, it was also stated that caregivers shoulder the blame for everything wrong that happens in the hospital according to the social media and the public at large. Respondents in this research stated that the working atmosphere does not support the development of human caring attributes. Respondents in the present research nurses' safety at work are not guaranteed. The contributors in this investigation believe that nurses might end up taking their frustration out on patients or patients' relatives due to job-related frustration.

The present research concurs with other studies. Atmosphere refers to the societal, intellectual, expressive features that might influence on the situations of the healthiness of a person (Jarring 2012: 18-22). NEIs have the duty to make certain that undergraduates obtain decent integration of the theoretical and practical learning, to accomplish their scholarship consequences as specified on their curriculum (Bruce *et al.* 2011: 284). Theoretic and practical ought to be harmonised when coaching the undergraduates (SANC 2013a: 38). The SANC minutest prescripts and guiding principles linking to the experimental training (SANC 1994: 9) argues that the inclusive goalmouth of the experimental training is to deliver undergraduates with connotation filled education prospects in all aspects of the assignment considering their year of study. The consequences of this research contradict the discoveries by Setati (2013: 49) that undergraduates were assigned tasks considering their phase of training and were directed. Nevertheless, approves those of Setumo (2013: 57) and Mothoka (2015: 73) who discovered that undergraduates were not allocated considering their experimental scholarship outcomes. While Sengstock (2009: 109) discovered that scholars' knowledge acquisition prospects were obstructed by assigning tedious responsibilities to them. This implies that there is a necessity for the teamwork of all the nurse training stakeholders and find the solution to the prevailing problem in this country; otherwise, the caring skills and competencies of the professional nurses will always be questioned.

7.9.2 Low staff morale

Staff morale is reduced significantly due to lack of resources some nurses opt to absenteeism rather than being on duty argued the respondents in this investigation. The present research exposed those nurse managers but you find that people at Stores may not even give them half of what they required. Participants in the current study also revealed that nurses at some point have to write their names on the disposable plastic aprons so that they will re-use them again. Operational managers in the wards should be vigilant enough to be able to pick up any gestures from their staff members that might suggest that the emotionally unstable or needs some extra support or referral. Nurses in this study articulated their encounters of how devastated they were when patients complicated due to shortage. The contributors in this research associated the high absenteeism rate amongst the nursing staff in the wards with the poor management style and the lack of communication. Contributors in this investigation try to instil quality nursing care to the nursing students by relating their experiences regarding the South African Nursing Council cases and their consequences. Nurse educators in this study cited that most of these nurses who came to nursing for other reasons other than love for the nursing profession would present with a high rate of absenteeism during the clinical placement. Nurse educators in the current study also revealed that some nursing students that are highly committed to their work end up booking themselves off sick because they are physically exhausted according to the participants in this study. The burden of diseases that nurses are faced with these days is too much for them to care for all the patients in their unit according to the nurse educators in this research. Nursing learners in this investigation when clinical facilitators are seen during the clinical placement they serve as a support system and a shoulder to cry on for these learners.

The discoveries of the current research are congruent with the existing body of literature. The responsibility of administrators in a healthiness institution is to make sure that tasks are accomplished in PPE and with all the indispensable assets that empower personnel to provide excellence

compassion for the profit of the healthcare users (Germain and Cummings 2010: 433). According to Zurmely, Martin and Fitzpatrick (2009: 383), the reduced determination amongst the tending personnel adds to nonattendance, the absence of enthusiasm, an augmented personnel throughput over and above personnel accumulative stages of tension, hopelessness and lastly exhaustion. Exhaustion directs to adverse outlooks that ultimately place the clients at danger of getting underprivileged client compassion and the nursing students may inherit and copy those negative attitudes and low morale from their role models in the clinical areas. In the opinion of this difficult, it appeared crucial to develop guidelines to enhance the human caring attributes amongst the undergraduate nursing students in mutually the lecture hall and the experimental milieu to eventually promote the rendering of quality patient care.

7.9.3 Hospital management issues

Some partakers in this investigation stated their apprehensions about the political influence on the nursing profession. The nurse managers raised their concerns regarding the political decisions that the politicians make with inadequate consultation at an operational level but only to find that it has a negative influence on implementers. Nurse Managers in the current study believed that politicians should deal with health care workers' challenges, instead of making unfounded assumptions about the decline in the quality of care e.g. nurses are misbehaving because they are no longer wearing the white uniform. The current study also revealed that the nurse managers wished that hospital CEO had a nursing background. Because according to them, a person who has worked in award at least that person knows how hectic it is so that when they are drawing up their hospital budget and it is writing motivation for a vacant post to be filled, they will be having an insight of patient acuity and several required staff. Some respondents in this investigation said that the reason for the deficiency of assets is ascribed to the fact that the person in charge of the healthcare institution does not have the nursing background. Nurse educators in the current were also concerned

about the way the procurement process has been made to be so complicated because so many authorities should approve before the order is received. Nurse Managers also raised their concern regarding the about the moratorium that exists regarding the employment of the new staff members in the department of health. Some nurse managers in this study stated how frustrating it is for them to order some essential resources for their wards only to be told that there are not enough finances to pay for their order. Nurse Managers in this study were worried about the amount of paperwork that according to them was as duplication of the same thing, and they claimed that was taking most of their time instead of focusing on patient care.

Department of Health affirms that caregiver administrators are in a crucial situation to direct the carrying out of numerous recommended healthcare improvements (Department of Health 2013: 23-27). Nurse administrators come across numerous tasks, counting various contending stresses, absence of official expert and regulator of assets, non-existence of or obsolete employment explanations, absence of backing from directors, difficult relations with physicians, and personnel nonattendance, among others. They also stated that there has been a sturdy deterioration in official, devoted nurse governance in tending direction posts at nationwide and provincial healthcare facilities associations in South Africa with a progression of in non-carer experts in management and administration posts. This organisation method has unintentionally directed to the forfeiture of course and deteriorating confidence of caregivers and midwives. Mid administration is a significant foundation of backing, counselling and exemplar of brilliance inpatient compassion for innovative applicants into the occupation (Department of Health 2013: 23-27). Therefore, this implies that there is a need to strengthen, support and equip all the nurse leaders with the necessary skills for them to be able to lead effectively.

7.10 MAJOR THEME 6: MEASURES TO ASSIST AND SUPPORT NURSE EDUCATORS AND NURSING STUDENTS TO ENGAGE IN NURSING EDUCATION AND TRAINING TO IMPROVE THE QUALITY OF PATIENT CARE

The contributors were questioned to share their view regarding the recommendations that can be put in place to assist and support facilitators and undergraduates engaging in nurse instruction and training to improve the quality of patient care. The participants described the measures that can be put in place to assist and support facilitators and undergraduates engaging in nurse instruction and training to advance the excellence of client care as a) the revival of the hospital-based Clinical Teaching Department, b) the role of nurse educators in the clinical teaching, c) the duty of facilitators in the clinical teaching, d) the confirmation or feedback, e) the pre-exposure to the ward's situation for all the applicants. Their responses follow hereunder.

7.10.1 The revival of the hospital-based Clinical Teaching Department

Participants in this study said there is a need to revive the clinical teaching departments that are hospital-based. The nurse educators in the current study cited that the revival of those hospitals based clinical facilitators would also have an optimistic influence on the performance of the tending procedures in the wards. they will go to the ward and monitor all the nurses how they do their procedures, unlike these from college because when they go to the ward they only focus on students, besides, the attitude they get from the permanent staff is very unwelcoming and negative. The facilitators in the current investigation argued that the revival of the Clinical Teaching Department would assist the nursing students not only with competency but also with the emotional support as well according to the respondents in the present investigation. Undergraduates need a person who is going to be there with the nursing students almost every day from morning until they knock off according to the facilitators in this research. According to the undergraduates in this investigation, the revival of the clinical teaching department will help to complement the good work that is done by the nurse educators. There is a

need to revive the clinical mentors and the clinical preceptors in the clinical area according to the nurse managers in the present investigation.

Findings of the present investigation are congruent with the existing literature. Nurse educators should also ensure collaboration amongst HEIs/NEIs and CLE (Borrageiro 2014: 20). Bruce *et al.* (2011: 284) mentioned that the duty of the facilitator must spread outside the lecture hall, where they devote adequate period to experimental instruction and experimental supervision and support of undergraduates. NEIs/ HEIs must have the experimental approach for backing scholars for the period of the experimental training (SANC 2013a: 15). According to Mete and Sari (2007: 437) in the research of undergraduates' anticipations of PBL and special effects of instructors' conduct on learner nurses, the undergraduates showed that they anticipated instructors to be merry, good hearers, displaying a good sense of judgement, and endure to be approachable even external lessons. Their findings were congruent with those of Kotze's (2008: 189) view on the epitome character of the facilitator. Borrageiro (2014: 20) proclaimed that learner nurses in Western Cape were guided and supported by the experimental instructors but their timetable was irregular and inadvertent. Anderson (2015: 49), state that the professors must be retold that caregivers acquire knowledge greatest (as mature students), in a setting in which there are backing and direction from supporters. This writer further proclaims that grown-ups study greatest when the theoretic is joined with a drill, in a setting which is favourable to knowledge acquisition and all participants have shared admiration and dependence. Bruce *et al.* (2011: 255) a preceptor denotes a professional nurse instructor who performances as an exemplar and ensures that learner carers advance from their practical exposure. Ma, Li, Liang, Bai and Song (2014: 42) sustain that for a scholarship to transpire, clinical facilities ought to have clinical instructors, compassionate facilitators and a compassionate knowledge acquisition milieu. In some circumstances, instructors were accessible at the clinical settings, but were not exactly qualified for experimental accompaniment, for that reason learners did not obtain experimental response (Eta, Atanga, Atashili and D 'Cruz 2011: 28 and Magobe, Beukes

and Muller (2010: 525-531). This implies that for the revival of quality patient care there is a need to re-instate the hospital-based clinical teaching departments in all the CLEs.

7.10.2 The role of nurse educators in the clinical teaching

The study also revealed that clinical instructors and lecturers should be more visible and involved in the clinical learning area. The nurse managers in this study thought that their lecturers were always in the clinical learning area with the students unlike the nurse educators nowadays. They were the ones who were teaching the nursing skills in the wards e.g. patient admissions and bed baths. Nurse Managers also raised their concerns regarding that these clinical instructors, if they do come to the wards they take students away from their wards; For example, from a paediatric ward, they will take students from the ward for hours and hours instead of doing whatever procedure in the ward where those learners are placed. This study also revealed that there is a barrier that exists between the lecturers/ clinical facilitators and the ward sisters. Nurse educators are seen as monster or a monitor who is there to see the wrong things that are done in the ward when they go to the wards to accompany their students. Ironically all the nursing students in this study were so happy about the level of support they were receiving from their clinical instructors. Some nursing students in this study commended their lecturers for treating them well and showing concern about them in totality.

The SANC R425 (1985) stipulates that an institution providing the four-year comprehensive nursing programme should provide the undergraduate nursing students with both classroom and clinical learning opportunities. The clinical learning component, which is facilitated through clinical accompaniment by the nurse educator, takes place in the CLE, and this is consistent with the requirement for training (SANC R425, 1985). Chan and Ip (2004: 665-666) affirm that clinical practice forms a vital component in the nursing curriculum and should be acknowledged as central to nursing education. These researchers cited that the CLE enhances the undergraduate nursing learners'

opportunity to develop attitudes, competence, interpersonal skills, critical thinking and clinical problem-solving abilities.

Baraz, Memarian and Vanaki (2015: 150) state that there appears to be a lack of evidence to support the theory that spending time in the clinical practice is associated with the development of the nurse educators' competence in either nursing or teaching practice. These authors argue that just having the knowledge and skills to teach and support nursing students learning do not necessarily equate with clinical knowledge. Whilst, Sayers, Salamonson, DiGiacomo and Davidson (2015: 48) argue a reasonable expectation would be to require from nurse educators' speciality education that is at least a master's degree level. Nurse educators play a very important role in the CLE because they are responsible for providing a link between theory and practice.

According to SANC (R425, 1985), on-going clinical accompaniment in approved CLEs by nurse educators and registered nurses is the required support that should be offered to ensure the production of mature professionals. The nurse educator is expected to spend at least 30 minutes per fortnight per student in the CLE. To gain appropriate clinical nursing experience, knowledge and skills during the four-year comprehensive nursing programme, pre-graduate students must work in various CLEs (SANC R425: 1985). Therefore, this implies that it is vital for the nurse educators to have pre-planned clinical visits, which meet the clinical needs of the nursing students. These structured clinical visits should be planned together with the CLE nursing personnel to minimise unnecessary clashes. The nurse educators should cultivate a good relationship between the NEIs and the CLEs. Lastly, nurse educators should not present themselves as nursing students' police or fault-finder but should have a positive attitude of supporting the nursing students in realising their specific learning outcome.

7.10.3 The confirmation or feedback

The current of this study revealed that nurse managers need to recognise and reward good behaviour from their staff to re-enforce it. It serves as positive feedback. Nurse educators in this study recommended that nursing personnel who make efforts to work hard despite the prevailing circumstances need to be rewarded for their effort. If good behaviour is not recognised by supervisors, which has also a negative impact on the care giver's attitude. Nurse educators in this study suggested that giving the praise to the subordinate when it is due does serve as positive re-enforcement. The nurse educators in the clinical setting should be responsive to students' needs; observe and give feedback to students, and create a supportive environment for learning (Darcy Associates 2009: 16). Simulation benefits students by enhancing active learning, a safe learning environment, assessment, immediate feedback to the students, increased confidence, learning at their own pace, and unlimited repetition of learning opportunities (Bruce, Klopfer and Mellish 2011: 243). Therefore, this implies that supervisors need to give meaningful feedback and support all nurses in the clinical area towards the attainment of the desired level of proficiency.

7.10.4 The pre-exposure to the ward's situation for all the applicants

The participants in this study recommended pre-exposure to the ward's situation for all the applicants before the beginning of the actual training. Some participants in this study recommended that schools should allow grade 10 pupils to come to do experiential learning in hospitals so that they have an idea of what being a nurse entail, before being admitted to training. Neilson and McNally (2010: 11) conducted a qualitative study on how nursing could be made more attractive as a career choice for high academic achieving school pupils. The school pupils in the same study questioned why departments of nursing within universities have not made the effort to link with schools as other departments have. The pupils pointed out that "nursing cannot afford to ignore the opportunity to engage much more actively with schools regarding nursing as a career choice and to do this in a meaningful

and productive way in early secondary school and possibly in primary schools.”

7.11 DISCUSSION OF FINDINGS IN RELATIONSHIP TO THE CONCEPTUAL FRAMEWORK

Watson’s Caring Theory was utilised as the preliminary opinion for the conversation of this investigation. Accountability of the carer in compassion brashness is to assist somebody to discover the influence and courageousness to contract with lifespan (American Nurses Association 2010:4). Even though consideration is a personal observable fact, there are directorial philosophies, which supported the investigator to assess the considerate feature of the undergraduates. Compassion, executive, coaching and knowledge acquisition, confidence and reliance, environment, trust, communication of emotions, mystical performs and wonders (DiNapoli, Nelson, Turkel and Watson 2010: 18).

This theoretic background concentration on interpersonal and transpersonal processes in human care. It also presents an effective model for understanding the concept of caring. The four major concepts of the nursing as explained in Watson’s theory provided the theoretical perspective of the study. In this study, a person is perceived as the oneness of mind-body-spirit-nature where the caring relationship is based on the wholeness of a person and not understood as parts of the whole. The health perspective in this study referred to the harmony within the body-mind and spirit, while the environment is perceived as the non-physical energetic field and nurse being seen as the environment. Lastly, the nursing perspective of this study refers not only to science but also to the art of nursing. The Caritas processes entail the Caritas language for the nursing practice and the key concepts for the measurement of caring within the nursing practice. The study aimed to critically analyse the role played by theoretical and clinical learning experiences in influencing the development of human caring attributes among undergraduate nursing students and newly graduated professional nurses, to establish clear

guidelines that can be used by lecturers to enhance human caring attributes among the nursing students. In the current study, all nurse learners and newly graduated professional nurses have perceived their theoretical learning experiences as sufficient and relevant to their requirements as professional nurses. According to all the participants in the current study, there are challenges concerning the integration of theoretical learning into a clinical learning experience.

Results of the current study revealed that all the participants are of the opinion that expressive nursing care is more important than the instrumental nursing care. Watson's philosophy (1985) identify expressive tending compassion as activities that establish nurse-patient relations that are categorised by faith, reliance, confidence, kindness, understanding, trace, balminess, and authenticity. Expressive nursing activities also include such behaviours that would support surveillance of the patient and promote comfort. It was also clear in the study that as much as participants would prefer to be more expressive in their nursing care there was many hindrances in realising their goals. Some of the trials in the CLE were identified as extrinsic factors the personal experience of the nurses as patients or patients' relatives, religious beliefs and cultural background of a nurse, inappropriate use of gadgets by nurses, peer pressure from other colleagues. The following challenges were also identified: impact of the rise in the number of social ills in our communities, inadequate selection process/ wrong career choice, lack of support mechanism from nursing management and NEIs management, role models' behaviour, nurse educators with a negative attitude towards nursing, role of the professional nurses and operational managers in student teaching, theory-practice gap. Lastly, the following challenges were also identified: emotional support for nurses / student nurses in dealing with negative patient outcomes, inadequate involvement of the multi-disciplinary team in nursing students support and guidance, appearance of caregivers as perceived by the media and community and nurses' rights versus patients' rights, un-conducive working conditions, low staff morale and the hospital management issues. The detailed discussion about their responses follows hereunder.

7.11.1 Human being /person (patient and the nurse)

Human being refers to the appreciated individual who is receiving care in an appreciated technique. A human is seen as the incorporated practical organism and the combination of his diverse body parts. The difficulty of the person signifies that it is not always useful to distinct the impartial and independent being in a creature. A person is swayed by the interior and exterior milieu and distinct and cooperative features. Watson believed that individuals are unitary total who are personal and exclusive and have internal power and possessions that can be drawn on if confronted with healthiness encounters (Schroeder and Maeve 1992: 25-38).

Watson also believes that it is the caregiver's business to support the client receive synchronisation in the thoughts, physique and ambience. This harmony will create self- awareness, self- respect, self- healing and self- care process within the client. Watson's (1985) human caring was appropriate to the awareness of caring by the participants in this study. Caring behaviours begin from the early collaboration amongst the caregiver and the client (Watson's 1985). Larson and Ferketich (1993: 690-707) defined caring as deliberate activities that transfer somatic care and expressive compassion while stimulating a sense of safety and security in another. Watson's (1985) philosophy of human compassion applied to the findings of the current study. The findings of the focus groups discussions and semi-structured interviews revealed human caring as there must be identified need for a person to be cared for, human caring as showing the patient respect and the dignity, human caring as being sympathetic and empathetic with the patient, human compassion as expertise, human consideration as helping, human caring as nurses showing care and concern for patients and human caring as the therapeutic use of self. The discoveries of the present investigation identified a caring nurse as being providing the client health education so that he/ she can make an informed decision about their health, supporting the patient, giving good physical care, giving instructions or teaching the patients, treating patient information confidentially, creating the client bodily or expressive

contented, serving to decrease the healthcare user's agony, inspiring the healthcare user to appeal if there are complications, showing respect for the patient and giving good physical care.

The lowest mean responses rates were noted for the following 12 responses because the four of them were the same in terms of mean and could not be separated: meeting the patients' stated and unstated needs, be enduring or untiring with the care receiver, responding quickly to the patients' call, paying special attention to the client, watching over the healthcare user, returning to the client voluntarily, managing equipment skilfully, being cheerful with the client, assisting the healthcare user to grow, spending time with a client, touching the patient to communicate and trusting the healthcare user. Four dimensions of caring were identified in this research. The highest dimension of care identified in this study Respectful Deference to Others is considered a significantly more caring behaviour than the others = 233.702, $p < .0005$, whilst Positive Connectedness was considered less of caring behaviour.

There was a significant agreement that 'attentively listening to patients' is a caring behaviour, $Z = -13.882$, $p < .0005$ in the current study. Paying attention is associated with qualities, for example, replicating, succinct, exploring and keep up look directly in the eye or unspoken signals to approve that the caregiver is paying attention (Dziopa and Ahern 2009: 3). As you pay attention to the clients, assume an open-minded outlook, part knowledge with the client and offer complete consideration as this will cause the client to sense that he is of worth to you and you are attentive to him (Scott, *et al.* 2008: 320). The consequence of the scholarship by Scott *et al.* (2008: 320) acknowledged that faith is the end outcome of the appropriately originated association and not the contributing factor of a prosperous association. The scholarship indicates that there are procedures that lead to the faith consequence: Firstly, appreciating the client through the showing of open-minded outlook, dependable being there, and attaching with the client. Secondly, the obligations of supremacy, caregivers depart the facts with the client at their juncture of comprehension. Thirdly, the capability to

demonstrate obligation to the association by rendering the activities that are related to compassion (eye communication, amused, proper touch etc.). All the above actions can only be recognised if the caregiver is collaborative and pay attention efficiently.

7.11.2 Nursing

The objective of nursing “is the assistance individuals achieve an advanced grade of synchronisation within the intellectual, physique and ambience which creates self-awareness, self-respect, self-sustaining and self-care progressions even though cumulative variety (Watson (1985: 49). Nursing is focused on assisting clients to find connotation in their survival and involvements, to aid determine interior device and influence, and outshine at self-healing. The milieu is supposed to affect a creature’s healthiness (Watson 1979). The discoveries of the investigation displayed that there are many challenges that may influence negatively in the goal of nurses to help clients/patients under their care. Therefore, for the healing to take place the caregiver should be in a good state mentally, emotionally and physically.

7.11.3 Environment

Environment refers to the societal, intellectual, expressive features that may influence on the state of affairs of the healthiness of a singular (Jarrin 2012: 18-22). The study also revealed that nurses are striving to attain their emotional and psychological well-being due to un-conducive working environment, lack of support and shortage of equipment and human resources. Therefore, the employer and NEIs have a duty of ensuring that nurses are exposed to a good working environment.

7.11.4 Health

Watson, (2012: 1) approve the WHO explanation of healthiness of uttering that health is not purely the absenteeism of illness but the comprehensive corporeal, intellectual, and societal healthiness. Distinct meaning: The person

finest delineates Quality of health thus desires for healthiness is exclusive among all the personalities. An individual requires to discover own connotation of what healthiness is to her and not to the universal public of clients. Subjects in this investigation started that human caring does not only centre on the somatic well-being but they supported for complete care. According to the discoveries of the current study for caregivers to be capable to render quality patient care, they need to feel loved and cared for holistically as well.

7.12 SUMMARY OF THE CHAPTER

This chapter provided a discussion and interpretation of both quantitative and qualitative data findings. The participants in this study have declared that caring for people in need of care is their fundamental concern, however, this goal can only be realised under conducive working conditions. The NEI's has a responsibility to align their curriculum to put more emphasis on the psycho-social role of the professional nurse, and the role of effective communication, emotional intelligence, cultural competence as well as caring characteristics. In the next chapter, the establishment of clear guidelines for nursing lecturers will follow.

CHAPTER 8: ESTABLISHMENT OF GUIDELINES FOR NURSING LECTURERS TO ENHANCE HUMAN CARING ATTRIBUTES AMONGST THE NURSING STUDENTS IN KZN

8.1 INTRODUCTION

In the previous chapter, the results of the current study were interpreted for both the quantitative and qualitative phases, as well as gaps were highlighted and discussed as per participants' responses. Chapter 8 presents and proposes guidelines clear guidelines that can be used by lecturers to enhance human caring attributes among the nursing students. The proposed guidelines were also the sixth and final objective current study. These guidelines are based on the findings of the current study, the intuitive insight of the researcher and recommendations from scholarly work as evidenced during the literature search.

8.2 PROCESS OF DEVELOPING GUIDELINES

The focus of the study in all the information that has been presented thus far has been associated with the first five objects of the investigation follow hereunder:

- Assess the nursing students' and nursing educators' understanding of the concept of human caring.
- Discover and pronounce the internal and exterior features related to the development of human caring attributes from the perspective of the nursing students, newly graduated nurses and nurse educators.
- Determine the nursing students' and newly graduated nurses' experiences in both the theory and the clinical setting that contributed to the development of human caring attributes according to their perspective.

- Explore and describe expertise and capabilities that are desirable to be efficacious at kind-heartedness from the perspectives of the participants.
- Determine the association between the working environment and the development of human caring attributes.

The discoveries guided the development of the proposed guiding principles. Guiding principles were articulated from six main focusses that arose from the participant responses. All the participants' responses gathered from the semi-controlled dialogues, prominence groups' deliberations and the responses from the questionnaires were taken into consideration during the guideline developing process.

8.3 SOLICITATION OF THE THEORETICAL STRUCTURE TO THE EXPANSION OF THE GUIDING PRINCIPLES

Grove, Burns and Gray (2013: 41) argue that a theoretical structure affords an underlying principle and construction that direct the expansion of the investigation. It also formulae comprehension on which the investigation is founded, enabling the investigator to connect the conclusions of the investigation to the existing literature and conceptualize this in CLE. It is also prepared up of suggestions, arrays of conceptions and declarations incorporated into the expressive structure. Therefore, the initial phase in the expansion of guiding principles in the current study was the contemplation of the theoretical structure as defined in Chapter 3. All conceptions in the structure were practical and observed, to provide structure to each guideline. The theoretical outline of the current investigation and its concepts allowed for the proposed guidelines to be formulated.

8.4 PURPOSE OF THE GUIDELINES

Guiding principles are apparatuses premeditated to advance the excellence of healthiness maintenance when utilized meritoriously, they would progress well-being consequences. The nurse educators and nurse managers, as well

as learner nurses and newly, graduated professional caregivers, as prospective operators of the guiding principles were contributors in the current investigation when the empirical data was generated. The guiding principle was associated with the recommendation expansion instructions which designate patients' favourites, the users' experiences and their morals must be measured when evolving guiding principles (National Health and Medical Council Research Council (NHMRC) 1991: 1; WHO 2012: 35). WHO (2012: 1, 9, 17) stated that effectively developed guiding principles must be affordable in using obtainable assets. Clear guidelines were established to enhance the human caring attributes amongst the undergraduate nursing students in KZN.

The main discovery that arose from this investigation was that crucial qualities such as compassion and human compassion attributes in the diverse role performers have a substantial inspiration on the expansion of learner nurses' human caring attributes in the instruction and teaching environment. The guidelines also summarise the subject matter covered and the discoveries of the current investigation. The researcher perceives learner nurses as adult learners. On inception the investigator attention was the enhancement of the human caring attributes amongst the nursing students from the nursing education perspective, however, the discoveries from the semi-organised dialogues and single-mindedness group interviews exposed the significance of the CLE on the progression of the human caring attributes and the theoretical learning is as important as well. Clinical instruction and CLE plays a vital role in learning. Within the teaching and learning environment, various constituents influence nurse learners' human caring attributes. Educator's desire and inspiration for the nursing profession, their motivation and ability to teach along with their character may influence the excellent instruction and preparation delivered. Operational managers' and professional nurses caring character and motivation towards nurse learners' guidance and support within the clinical learning environment (CLE). Learner nurses' desire for this profession and their attitudes will influence the expansion of human caring attributes, knowledge and proficiency.

Learner nurses join the nursing profession with their own preconceived experiences and assumptions, prior learning and intrinsic and extrinsic motivation to learn (Daily and Landis 2014: 2065). Nurse educators and nurse learners come across numerous trials that affect the excellence and consequence of the instruction and scholarship. Enhancement of the development of the human caring attributes amongst the learner nurses, nurse educators must incorporate the principles of the adult learning principles when facilitating the learner nurses. The core curriculum has an important responsibility in the instruction and scholarship approaches used. The constructivist model was acknowledged as the best appropriate for innovative teaching approaches plus for coaching mature pupils. The expansion of human caring attributes is reliant on the numerous learner-based instruction and scholarship approaches as outlined in chapter 2. Waltz, Jenkins and Han (2014: 392) assert that the instructive approach in nursing and other healthiness careers at the beginning of the 21st period was primarily educator focused as demonstrated by the usage of old-fashioned instruction approaches like addresses, talk deliberations and conferences. Conversely, as the centuries passed progressively instructors commenced to practice learner-focused instruction approaches such as assemblage exertion, give-and-take scholarship, character players, and occasion- founded scholarship.

The single-mindedness collection deliberations with nurse administrators and the nurse educators over and above the partly organised dialogues with nursing students and newly graduated professional nurses revealed the need for a supportive environment for all nurses regardless of their professional rank. Consulting and involving nurses of all categories in policy changes, which concerns them directly or indirectly is a crucial persuasive feature in the theoretical and experimental knowledge acquisition milieu. Therefore, the guidelines demonstrate the impact of the positive teaching-learning milieu, adult learner nurse, facilitators, trials, prospectus, learner-focused coaching, knowledge acquisition and valuation approaches; unit managers and

professional nurses plus qualities for instance desire and compassion on the growth of student nurses' human caring attributes.

8.5 RATIONALE FOR THE GUIDELINES

The guiding principles progress the excellence of care utilising involvements that have extreme prospects to profit client upkeep (NHMRC 1999: 1). Guiding principles perform as established the ethics, which are established to direct the suitable run through and policymaking in healthcare (Ministry of Health 2011: 4). The guiding principles are apparatuses, which expedite incorporation of investigation consequences into the preparation and curative determinations (Fevers 2010: e347). The education of nurse learners in South Africa takes place in the training institutions accredited by SANC. The SANC as a professional controlling body requires that nursing students registered for R425 should be successfully trained in all the four disciplines to be enrolled as a registered nurse (SANC 1985; 1). To fulfil this requirement, all students should successfully meet the objectives in all four disciplines. This is to ensure that learner nurses are adequately in these disciplines to combat an escalated number of malpractice cases in health care institutions as a result of uncaring, incompetent nurses who impact to the deterioration of excellent nursing care.

Application of the developed guidelines by the stakeholders will facilitate the production of caring nurse graduates who can be placed in the healthiness facilities and improve excellence patient care and minimise litigations against the Department of Health. The developed guidelines are not legally binding but are recommended as a guide to expedite incorporation of theoretical learning into practical learning and increase nursing student support as well as increase the support of nurse managers who are also faced with several challenges emanating from the cost containment and reduction of personnel, equipment and supplies by the major stakeholder the Department of Health.

8.6 SCOPE OF THE GUIDELINES

The guidelines are targeted at policymakers in the KZN Department of Health as well DUT, nurse educators in KZNCN and DUT and Nurse Administrators and qualified healthcare providers in the KZN Department of Health establishments accredited for learner nurse training. These aforementioned stakeholders are tasked with the planning, implementation and evaluation of learner nurses' training within the KZN Province. The clear establishment of these guidelines was guided by the NGT technique to make certain that the aim and purposes of the investigation are realised (Evaluation briefs 2006: 7).

8.7 RECOMMENDED GUIDELINES

The primary purpose of the present investigation to develop guidelines to enhance human caring attributes among the undergraduate nursing students and nurse graduates in KZN was effectively accomplished as evidenced through the conclusions presented above. The existing investigation provided positive perceptions of human caring concept in a nursing education setting, that serves as a primary phase in evolving and articulating effective instruction and experimental approaches.

The current findings have implications for the nursing academic world. Labrague et al. (2015: 344) argues that the primary purpose of nursing instruction and preparation is to rendering learner nurses to an inclusive interpretation of considerate discipline, to enable them to develop as compassionate personalities, and many investigators come to an agreement that the efficacious expansion of learner nurses into a proficient obligation as compassionate caregivers is reliant on the CLE. According to the findings of the current study, concerns of the intrinsic and extrinsic factors that contribute towards the development of the human caring attributes amongst the pre-registration learner nurses in KZN need to be considered. Apprehensions were highlighted in the form of themes as set out in Table 6.2 in chapter 6. The investigator recommends the following guidelines for the various stakeholders that engage in the coaching and scholarship for the pre-registration nursing

programme. For this chapter, the proposed guidelines have been divided into subdivisions.

Table 8.1: The four sets of guidelines developed

Four sets of guidelines developed	Targeted stakeholders	Focus Area
Guideline A	Guidelines for policymakers in the KZN Department of Health.	<p>-Department of Health should increase the subsidy to nursing institutions, to fill the vacancies and provide adequate human resources and material resources in the NEI's and state-own hospitals.</p> <p>-The provincial and national department of health should create and fund posts for Clinical Placement Co-ordinator as well as for the clinical preceptors.</p>
Guideline B	Guidelines for NEIs/ HEIs	<p>NEIs/HEIs should adopt transformative nursing curricula and use pedagogically sound, creative, innovative, fundamental and emancipator tactics in teaching, investigation and clinical and the meaningful integration of technology to produce a more profession-ready nursing graduate.</p> <p>-The NEI's/HEIs are tasked with the responsibility of ensuring quality rather than quantity in their throughputs/ products of undergraduate nurses.</p>
Guideline C	Guidelines for Nurse Educators	<p>-Nurse educators should design and implement innovative curricula within nursing instruction programmes that are at par with the international norms, quality and standards.</p> <p>-Appropriate linking and sequencing of the practice following the theoretical component should be employed by nurse educators.</p> <p>-The clinical accompaniment must be done by both the clinical instructors and nurse educators following a well-planned programme.</p>
Guideline D	Guidelines for CLE	<p>-Nurse Managers should also ensure that in their units there have reasonable levels of nurse-patient/ client ratio depending on the patient acuity in each ward.</p> <p>-Nurse managers should be able to give positive feedback to staff members verbal only and/or rewards.</p> <p>-Hospital management should handle all grievances immediately and professionally.</p> <p>-There is a need for the revival of the clinical teaching departments in all the CLEs.</p> <p>-Professional nurses and Unit managers should be accountable for training and mentoring learner nurses placed in their wards for clinical learning exposure.</p>

8.8 RECOMMENDATIONS FOR DEVELOPING GUIDELINES FOR STAKEHOLDERS

Discoveries of the present investigation highlighted the commendations prepared by participants, which were highlighted in Chapter 6. The researcher comments that developed guidelines be implemented by all stakeholders who are stakeholders in the preparation of learner nurses in the KZN Province to ensure that they are accepted in the clinical practice of the KZN health care institutions. In Table 8.1, the four sets of guidelines developed in the current study are displayed.

8.8.1 Guidelines A: for KZN Department of Health

The Department of Health is a major role player in nurse training and provision of quality patient care. This implies that without the buy-in of the department of health as a major stakeholder in the facilitation of nurse training and healthcare provision in South Africa is paramount for successful implementation of any model or guidelines in that regard.

8.8.1.1 GUIDELINE A-1

The Provincial and National Department of Health should increase the subsidy for the nursing institutions, to fill the vacancies and provide adequate human resources and material resources in the NEI's and state-own hospitals.

The provision of quality patient care at the KZN healthcare institutions is of utmost importance in the KZN province. Hence, the KZN Department of Health policymakers should ensure that patient safety efforts are on equal footing with the allocation of finance and other resources. Therefore, paying attention to sound policy and practice related frameworks which guide decisions about the allocation of material, financial, and human resources required for the attainment of a positive practice environment for enhanced quality patient care and effective training of learner nurses.

The rationale for the implementation of the developed guidelines

This may reduce unnecessary pressure on employees at all levels. This will also assist the nurse learners to have time to attend to their learning objectives rather than covering up for staff shortages. This will also alleviate the theory-practice gap because nurses will have enough equipment to perform the nursing procedures the correct way. Once all the vacant posts are filled this will reduce the workload amongst different healthcare employees and correct the unacceptable caregiver client ratios, and ultimately improve the quality of care provided. This will assist in minimising the improper utilisation of governments' finances and improve the service provision at the operational level.

Recommendation for implementation of this guideline

The following recommendations for the implementation of this guideline may be considered by policymakers in the KZN Province:

- The provincial and national department of health should have good monitoring strategies/policies to ensure that finances are utilised effectively, and for what they were meant for.
- The provincial financial policymakers should dedicate supplementary assets to cultivating compassion amongst personnel and nurse learners.
- Provincial financial policymakers should demonstrate adherence to the directives of the public finance management policy.
- The provincial financial policymakers should consult nurse managers at the operational level before finalising any policies that have a direct impact on their functioning e.g. procurement of equipment and supplies policies.
- To review the existing procurement policy to minimise/ shorten the period that elapses between the acquisition and the reception of necessary supplies and equipment.

- The provincial financial policymakers should ensure that staffing norms are sensitive to acceptable patient-nurse ratios in-line with the demand for care, and they should ensure that workload management is aligned to the disease profile, patient acuity and nurses' ability to perform.
- Therefore, consultation of nurse managers concerning all the above resources distribution is mandatory.
- The current KZN policy on nurse learners' intake needs to be reviewed so that it prioritises the involvement of NEI/HEIs personnel before the finalisation of recruitment of learner nurses for training.

8.8.1.2 GUIDELINE A-2

The provincial and national department of health should create and fund posts for Clinical Placement Co-ordinator as well as for the clinical preceptors.

Enhanced nursing instruction is obligatory to ensure that the present and forthcoming cohorts of caregivers and midwives are capable to render harmless, excellent, client-focused nursing service through all health care surroundings.

The rationale for the implementation of the developed guidelines

The positive contribution of the well-functioning CTD departments in all health care facilities cannot be overemphasised. The CTD department will ensure proper staff orientation and induction as well as standardisation of nursing procedures amongst nursing staff and learner nurses.

Recommendation for implementation of this guideline

The following recommendations for the implementation of this guideline might be considered by the policy-makers in KZN Province:

A Directorate of Nursing Service (DNS) with a sub-directorate of Nurse Education and Training must be developed at Provincial Health Departments, with a qualified nurse employed as Director of Nursing Services (WCPG model). A Clinical Placement Coordinator (CPC) centred at the DNS for the expansion and execution of synchronised experimental assignment coordination to make certain structured and proper assignment of learner nurses. CPC accountabilities are stated below:

- Organises location of all learner nurses in Provincial healthiness facilities and NPOs to confirm attainment of experimental consequences in the prospectus lacking overstraining the service area, sick persons and consumers; experimental locations must be completed with the contemplation of:
- Quantity of learner nurses in the programme(s) and the number of elements to which they may be placed;
- The former obligation of an explicit facility to a course;
- Parity- altogether the HEIs/NEIs must have impartial admittance to civic facilities;
- Precise requirements and scholarship prospects of the prospectus of each NEI/HEI e.g. sequencing; correlation of theory and practice.

-The Clinical Placement Coordinator (CPC) observes acquiescence with SANC (and CHE) stipulations, comprising site analysis of CLE to make certain that they are properly designated/ utilised to accomplish the clinical consequences of the prospectus.

-The Clinical Placement Coordinator (CPC) also accepts and administrates all applications and presentations for clinical location, and make sure that memorandum of agreements is prepared amongst the facilities and NEI/ HEIs.

-The Clinical Placement Coordinator (CPC) should also hold three-monthly conventions with the Clinical Programme Coordinators and chosen facilitators from NEIs/HEIs for the determination of observing experimental locations and principles of positive practise environment (Department of Health 2013: 91).

-Preserve present and progress novel associations with the CLE for learner locations.

8.8.2 Guidelines B: for NEIs/HEIs

8.8.2.1 GUIDELINE B-1

Nursing Education Institutions (NEIs) should adopt transformative nursing curricula and use pedagogically sound, creative, innovative, fundamental and emancipator tactics in learning, investigation and clinical and the meaningful integration of technology to produce a more profession-ready nursing graduate (Ferguson and Smith: 2012: 976; Pillay, Bozalek and Wood 2015: 516).

Authentic learning does not occur in a vacuum. Several socio-economic factors influence nursing education, such as the burden of disease, intergenerational effects of poverty, unemployment levels, social cohesion, culture and language, the cost of medical services and low access to health care centres (Muganga 2015: 30; Pillay *et al.* 2015: 516; Ranjbar and Emami Zeydi 2016: 98).

The rationale for the implementation of the developed guidelines

Therefore, the above-mentioned factors and many other challenges affect the acceleration of authentic learning concerning the human, time, material and financial resources and constraints, community participation, quality of nurse educators, the quality of learners from the diverse schooling system and global interconnectedness (Chabeli 2014: 5-9; Gölpek and Çiftçiouğlu 2014: 128). The primary goal of nurse educators' core-competencies is to produce a highly competent, independent nurse practitioner who will realise the healthiness essentials of the country and ultimately protect the community (Department of Health 2013: 91).

Recommendation for implementation of this guideline

The following recommendations for the implementation of this guideline should be taken into consideration by NEIs/HEIs in the KZN province:

-In service training, short courses or conferences should also be accessible to equip facilitators usage innovative coaching, scholarship and valuation approach.

-In service training, short courses or conferences must also be accessible to enable instructors on teamwork, acceleration expertise, team coaching, team administration and team subtleties.

-Nurse Education Institutions should employ suitably qualified candidates who possess the following core competencies as developed by SANC:

- Scholarship teaching and learning: facilitate learning;
- Educational and learner administration: simplify learner expansion, socialisation and usage of valuation and appraisal approaches;
- Curriculum development: participate in curriculum design and development in the nurse educator role;
- Research and knowledge creation: engage in scholarship and
- Research and knowledge creation: professional practice, ethical practice and legal practice.

8.8.2.2 GUIDELINE B-2

The NEI's/HEIs are tasked with the responsibility of ensuring quality rather than quantity in their throughputs/ products of undergraduate nurses.

Nurse educators should function in a positive practice environment with flexible policies for them to be able to function optimally and the provision of adequate training material is mandatory for quality ensuring purposes. The fundamental role of the NEI's /HEIs is to convey holistic caring and concern

for their employees'/ nurse educators, for them to be able to portray positive attitudes to their learners as well.

The rationale for implementation of the developed guidelines

Assurance of quality and adherence to SANC policies and prescripts during the provision of nursing education should be an everyday practice, in all the departments in NEIs/ HEIs. This will also ensure adequate learner guidance, monitoring and support during clinical placements.

Recommendation for implementation of this guideline

The following recommendations for the implementation of this guideline should be taken into consideration by NEIs in the KZN Province:

- The experienced nurse educator should be tasked with this responsibility by the management of the NEI. This will assist in identifying the learning needs of all the nurse educators while identifying their weak and strong points, so that support and guidance can be offered when necessary.
- This will be ensured by adherence to recommended facilitator-undergraduate student nurse ratio of 1: 15-20 (Department of Health 2013: 86). These are reasonable ratios for nurse educators to spend quality time with their learners in both theoretical and clinical learning environments.
- Instrument an all-inclusive plan to re-instate the nursing moral belief in the career, to advertise the career optimistic as a vocation of preference to prospective trainees for nursing courses. This comprehensive plan should promote the nursing career at high school phase to entice a virtuous crew of caregivers (Department of Health 2013: 12). This will also curb the problem of attracting people who do not like the nursing career or are ill-informed about the nursing career.
- Include professional and work ethics as obligatory modules of work-related instruction and CPD programmes for all stages of instruction and preparation for nursing midwifery training.

- Consist of moral code, learner-centred, team educations and automated mass media in the expansion and re-orientation of instructors.
- NEIs/HEIs should include clinical reasoning and human caring in the curriculum and assessments.
- NEIs/HEIs should offer the initiation, induction and coaching plan for newly elected facilitators.
- NEIs/HEIs management has a responsibility of empowering facilitators to be able to cope with the miscellaneous trials of the coaching scholarship milieu, for instance, by motivating collaboration and assisting facilitators to cope with restricted supplies.
- Include nurse educators in the preliminary design and proposal of NEI/HEI organisation to guarantee best practices and design of NEIs/NEIs to safeguard greatest performs and integrate PPE principles into the National Core Standards venture administered by the Office of Health Standards Compliance.
- Reinstatement Wellness Centers/ Employee Assistance Programmes (EAP) for NEI/HEI employees.
- Implement benchmarking facility to enable sharing of best practices.
- Explore the present guidelines on staffing proportions, professional healthiness and well-being as well as ferocity avoidance.

8.8.3 Guidelines C: for academia

8.8.3.1 GUIDELINE C-1

Nurse educators should design and implement innovative curricula within the nursing education curriculums that are consistent with the international norms, excellence and standards.

Authentic learning is an appropriate pedagogical approach for basic nursing education that, when implemented, will produce competent nurse practitioners. Amongst the many aspects of nursing in which the ICN is involved in the Code of Ethics for Nurses, which is important in the facilitation of authentic learning. It is organised into four principal elements: caregivers

and persons; caregivers and clinical training; caregivers and the occupation; and caregivers and colleagues, with the subsequent component highlighting the importance of continual learning (ICN 2012: 1-12).

The rationale for the implementation of the developed guidelines

The learner-centred teaching approach such as computer-generated learning, work focused theoretic scholarship, PBL, the case focused erudition, community-based education, project-focused learning may be selected by facilitators appropriate to engage nursing students to facilitate authentic learning during the theoretical and the clinical learning exposure in the accredited CLE. Hudson (2015: 48) and Nguyen and Walker (2014: 98) authentic learning develops lifelong learners, who continuously and actively engage in meaningful construction of their knowledge.

Recommendation for implementation of this guideline

The following recommendations for the implementation of this guideline should be taken into consideration by nurse educators in KZN:

- Curricula review should take place every 3-5 years to make certain that precedence in the CLE is imparted theoretically and theoretical learning is congruent for the modern practise (Department of Health 2013: 89).
- The investigator believes that both micro and macro curriculum review should be the collaborative effort between the CPC and clinical preceptors to promote the standardisation of procedures and avoid the confusion amongst the learner nurses.
- Procedure manuals must also be reviewed periodically ensuring its relevance to that particular context.
- Nurse educators should give learner nurses authentic tasks within the equivocal, unpredictable and multifaceted real-life contexts where the goals of such legislative authorities will be realised to effectively meet the national and global healthcare needs.

8.8.3.2 GUIDELINE C-2

According to the Department of Health (2013: 89) appropriate linking and sequencing of the practice following the theoretical component.

NEI/HEI must make certain that learners are allocated where their maximum learning opportunities and to ensure that knowledge acquisition does transpire in the CLE. Experiential clinical exposure should always be preceded by the theory coverage of the same theory outcomes, to ease the integration of theory into clinical. Therefore, collaboration and effective communication between the theory and clinical team is mandatory for authentic learning.

The rationale for the implementation of the developed guidelines

Real-life, integrative learning prepares learner nurses for real-world through the development of cognitive and affective skills needed to make informed rational decisions and effectively solve complex problems. This lifelong process translates into integration and application of the constructed knowledge to new different contexts, by creating opportunities for new possibilities (Chiang, Leung, Chui, Leung and Mak 2013: 1185).

Recommendation for implementation of this guideline

The following recommendations for the implementation of this guideline should be taken into consideration by nurse educators in the KZN Province:

- Theoretical and practical learning in the prospectus must be organised in-line with the curriculum prescripts, with delivery for experiential learning for role-taking.
- Placement for the practical exposure must be scheduled cooperatively amongst the chosen professors, from the academic institution and CPC in the facilities in a fashion that displays curriculum consistency, continuousness and straight-up the incorporation of theoretical information and expertise.

- Prior-practical deliberations must be conducted with mentors to prepare learners on precise prospects. Practical assignment for more than four weeks in CLE should be realised for role-taking (Department of Health 2013: 89).
- A well planned clinical accompaniment programme should be drawn in advanced and be circulated to the CLEs concerned.

8.8.3.3 GUIDELINE C-3

Clinical accompaniment must be done by both the clinical facilitators and nurse educators.

Department of Health (2013: 91) affirms that facilitators involved in theoretic coaching are also entirely accountable for experimental training and for supporting learner nurses to incorporate theoretical and experiential learning using suitable coaching and knowledge acquisition tactics.

The rationale for the execution of the developed guiding principles

The guiding principle and the proposed application is aimed at to improve the supervision and accompaniment of learner nurses by the clinical instructors and nurse lecturers in the KZN province. Nurse educators' eagerness and competence is crucial to cultivate caregivers that are proficient, knowledgeable and prepared for work-place. The constant support and availability of clinical instructors at the CLE will facilitate the support and guidance of learner nurses plus the incorporation of theoretic and practical training. This will assist nurse educators to keep them updated with latest trends and changes in policies and protocols, so as to update their classroom teaching. This implies that there would be reciprocal learning and benefit for both the NEIs/HEIs and CLE. Nurse educators are mature professional, researchers and teachers who can contribute to the clinical teaching of the ward staff and patients. Therefore, this would be more feasible where there are reasonable nurse educator student ratios or there is adequate staffing on the side of the NEI's/HEIs.

Recommendation for implementation of this guideline

The following recommendations for the implementation of this guideline should be taken into consideration by nurse educators in the KZN Province:

- Nurse educators must interact directly with healthcare users or consumers in the CLE, interrelated to the module they give a grounding in for ten percent of their period per annum e.g. in a 44-week educational calendar year. This implies that a total of 176 hours= 4 hours per (40 hours) week or 22 days per year.
- Nurse educators must also contribute to educational and academic actions that occur in experimental amenities such as ill-health and death conventions, doctors' rounds and discussions.
- Educational preparations and individual schedules/ almanacs must replicate designed calls to and conventions with experimental capacities by facilitators, proficient advancement and proficiency and clinical accompaniment (Department of Health 2013: 91).

8.8.4 Guidelines D: for CLEs

8.8.4.1 GUIDELINE D-1

Nurse Managers should also ensure that in their units there are reasonable levels of nurse-patient/ client ratio depending on the patient acuity in each ward.

Nurse administrators are in crucial circumstances to direct the execution of various suggested healthcare transformations. Nevertheless, administrators come across numerous trials, comprising various opposing difficulties, deficiency of official expert witness and the governor over assets, absence of or old-fashioned job explanations, deficiency of backing from managers, challenging relations with physicians, and personnel nonattendance amid others (Department of Health 2013: 23)

The rationale for the implementation of the developed guidelines

Hospital management should use the participative management strategies, by allowing all nurses regardless of their category to partake in the resolution constructing concerning any concerns related to the rendering of quality patient care e.g. staffing issues. This will also reduce the work-related stress amongst employees and improve mental well-being and ultimately have a positive impact on the quality of health care rendered.

Recommendation for implementation of this guideline

The following recommendations for the implementation of this guideline should be taken into consideration by nurse administrators in KZN:

- All members of the multi-disciplinary team should be engaged in strategic conferences regarding facility provision and permitted to contribute ideas for the itinerary for all programmed consultations.
- Hospital managers must make certain that they are frank and transparent on all progressions that necessitate being executed in CLE, with the purpose of having the buy-in of the implementers, of which most of the times are nurses.
- Consulting and involving nurses of all categories in policy changes which concerns them directly or indirectly is for that reason crucial prominent issue in the theoretical and clinical education acquisition setting.
- Provision of adequate human and material resources is mandatory for all CLEs, so that learner nurses learn the nursing skills the correct way.
- Improvement of the value of career for caregivers in all categories by creating PPE to enable caregivers to provide excellent client service.
- Nurses should be rotated periodically depending on the hospital policy e.g. yearly or annually. This will assist caregivers to discover other undertakings; attain more understanding and expertise or measures in diverse wards by personnel alternation as well as curb the issue of low staff morale and burnout amongst the nursing staff.

- Nursing students should have the status of learner nurse in the CLE. Learner nurses should not be utilised to cover for staff shortages.

8.8.4.2 GUIDELINE D-2

Nurse managers should be able to give positive feedback to staff members

Nurse Managers or supervisors should be able to give good or bad feedback constructively in a professional manner and timeously. All nurses should be made aware of their inadequacies as well as their adequacies and they need to be supported in dealing with their shortcomings. Therefore, all professional nurses as nurse mentors and supervisors ought to have the ability to talk effectively without hurting the feelings of the next person and be able to accept criticism directed to them by their superiors or subordinates.

The rationale for the implementation of the developed guidelines

This will serve as a positive re-enforcement to them. Nurse Managers should give praise when it is due. When a nurse administrator provides an affirmative or undesirable criticism, it serves to bring the positive change and avoid recurrence.

Recommendation for implementation of this guideline

The following recommendations for the implementation of this guideline may be considered by nurse administrators in KZN Province:

- Rewards should be given to staff members are performing excellently, to motivate others.
- Rewards can be in a form of prizes, monetary rewards or promotions.
- They should be able to give negative feedback constructively, they should not be perceived as judgmental and non-supportive by nurses.

- Nurse Managers should refrain from providing collective rebuke and as an alternative constructively provide straightforward rebuke so as to nurses and enable them to accept critics.
- Nurse managers must encourage openness and transparency, efficient communiqué and accurate channels of communiqué are important components of the positive working environment. In case there is the recurrence of negative behaviour staff members should be supported and referred for help appropriately without being judgmental.

8.8.4.3 GUIDELINE D-3

Hospital management should handle all grievances and negative incidence/s immediately and professionally.

The SANC indicators expose that grievances in contradiction of caregivers have amplified three hundred folding from 1996. The mainstream of disputes, there is a hint of undesirable defiance of the caregiver specialist that ultimately directed to performance or failure to perform which institute transgression. From SANC's recounted practised transgression incidences from 2003 to 2008, it is obvious that the privileges of nurses and patients were disrupted (Department of Health 2013: 25).

The rationale for the implementation of this guideline

To provide the public should with accurate, reliable information as early as possible, without an attempt to expose inadequacies of staff member/s concerned. After the negative incident has been categories as crime or practice breakdown, the next step would be to channel all incidents to appropriate structures for further management. In this approach the practice errors would be referred to the designated internal committee for adverse events; violation of legislation would be reported to the preliminary investigation committee of SANC, and criminal acts would be reported to the South African Police Services. Therefore, a system for classification of all incidents including a process map for management should be determined.

Recommendation for implementation of this guideline

The following recommendations for the implementation of this guideline should be taken into consideration by nurse educators in the KZN Province:

- Distinguishing practice breakdown and violation of the rules and laws governing nursing practice and criminal acts committed by nurses while on duty, is a critical first step in the integrated approach for managing practice breakdown.
- Proper investigations should be conducted following any negative incidence/s. circumstances that might have led to that occurrence of the incidence should not be left out when reporting that to the media or public. These investigations are to be guided by a commitment by all concerned to learn from the incident and to institute corrective measures that would prevent recurrence of similar incidents.
- Proactive communication directly with the affected patients and the media is an integral part of active management of practice breakdown.
- The establishment of a committee comprising of senior officials and practitioners who would institute an investigation of all cases of adverse events. This committee would be expected to develop a process map for the management of all adverse events. This committee would be expected to conduct reviews of all incidents with a brief to focus on how the incident occurred rather than who is responsible.
- In dealing with negative incidences commitment by management to systems should be reflected rather than who is responsible.
- Prevention of predictable errors is about ensuring that patient safety efforts are on an equal footing with finance and resource allocation and proactive management of risk factors inherent in care environments. Therefore, management should set up mechanisms for ensuring that adequate resources which would ensure that corrective actions are taken where gaps identified are allocated in all areas of need.
- The attainment of a positive practice environment is incumbent on an approach to the management of practice breakdown is strongly affected by the context and the working conditions.

8.8.4.4 GUIDELINE D-4

There is a need for the revival of the clinical teaching departments in all the CLEs

CTDs does no longer exist in most healthiness facility establishments; there are inadequate administration and supervision of learners; and universal deficiency of virtuous practical mentors. There is dissimilarity amongst the expertise and proficiencies of facilitators and the professional nurses in CLE. This is aggravated by the non-existence of communiqué amongst NEIs/ HEIs and CLE personnel.

The rationale for the implementation of the developed guidelines

Experimental exertion is an imperative fundamental fragment of nurse training. Experimental training is similarly imperative as theoretical learning. The CLE provides the essential learning opportunities that the learners require to assist them in their prospect undertakings as proficient and effective nurse graduates. For that reason, NEIs/HEIs make certain that experimental knowledge acquisition opportunities are augmented to enhance human caring attributes among the nurse graduates. The investigator believes that this will assist with standardisation of nursing procedures between the NEI's and the CLEs. This can only be realised when there are adequate human and material resources in the CLEs.

Recommendation for implementation of this guideline

Nominated Clinical Teaching Unit (CTU) or Clinical Teaching Department (CTD) respectively experimental learning institution and in the circumstance of regions, at each District Administrative centre, such components will be accountable for the following:

- The practical teaching of learner carers.
- The personnel expansion and work-related preparation of professional caring personnel,

- The induction and initiation of innovative tending personnel and community service nurses (CSN).
- An elected being, termed a Clinical Programme Co-ordinator (CPC) need to be employed by the Clinical health institution whose duty is the synchronisation of experimental knowledge acquisition occasions of learners from all courses.
- Experimental mentors are fundamental to the experimental coaching epitome and operate carefully CPC, facilitators and operational managers.
- Experimental instructors must be diverse selected for elementary and post-graduate prospectuses and identified to as generalist experimental instructors and professional experimental instructors separately.
- The universal experimental instructor will be hired by and account at the NEI's/HEIs nevertheless are located in the facilities with nominal employment in the CLE where learners are allocated and have complete entrance and contribution in facility matters that influence on experiential learning.
- Specialist clinical preceptors are hired by and account to the experimental facility (CPC) and have nominal employment in the NEI/HEI that allocates and coach advanced scholars (Department of Health 2013: 89).
- The obedience to commended fractions of individual Generalist Clinical Preceptor for all 15- 20 scholars and single Specialist Clinical Preceptor for all 2-5 scholars need to be observed. Global standards for sufficient experimental administration in undergraduate tending prospectus propose a percentage of 1: 10 (Department of Health 2013: 89).

8.8.4.5 GUIDELINE D-5

Registered nurses and Operational managers in charge should resume their responsibility for coaching and directing learner nurses placed in their divisions for clinical learning exposure ensure their incorporation into the multi-disciplinary healthiness crew.

The rationale for the development of this guideline

CLE management has a responsibility to train, teach and develop operational managers and professional nurses, to generate a setting that permits carers to study and upgrade themselves and to educate drill and coach learner nurses and sub-categories depending on the needs.

Recommendation for implementation of this guideline

The following recommendations for the implementation of this guideline should be taken into consideration by nurse educators in the KZN Province:

These professional nurses constitute the experimental administrative officialdom, which is integral for the efficacious putting into practice of the ideal by enhancing the responsibilities hereunder:

- Proficient consideration for clients / care receivers
- Health education for care receivers/ client care
- Supervising healthcare user precaution and directing nursing run through
- Investigating to expand carefulness and innovative nursing exercise (Department of Health 2013: 89).

Nurse Managers and professional nurses would find it easier to resume the above roles and responsibilities where there are reasonable nurse-patient ratios, adequate human and material resources. Inadequate supply of caregivers, impracticable amount of work, scarcity of equipment and supplies, hazardous operational conditions and professed prejudiced reimbursement are midst more or less the issues upsetting the career and recitation of carers and midwives and other healthcare specialists and healthcare labours in South Africa. The aforementioned does not only endanger excellence healthcare user carefulness, nevertheless the excellence of experiential learning and acquaintance of carers, midwives and additional members of the multi-disciplinary team.

8.9 EVALUATION OF DEVELOPED GUIDELINES

According to Thomas (2017: 38), developed guidelines should be evaluated by the various methods such as asking the experts that did not take part in the guidelines expansion process to analyse them for simplicity, interior reliability and suitability. The author further indicates that guidelines can at that moment be verified in designated healthcare surroundings to ascertain whether they are practicable for usage in monotonous exercise (Thomas 2017: 38). The last stage of guidelines evaluation should include a review subsequently a stated duration and adapted to consider innovative acquaintance and technological advancement. In the present investigation, the main goal of the development of these guiding principles was to recommend their implementation by stakeholders involved in learner nurse training during their placement in KZN health care institutions in KZN Province.

Thomas (2017: 38) states that for guidelines to be effective they should have all the 11 characteristics namely: legitimacy, affordability, reproducibility, dependability, illustrative expansion, experimental executorship, experimental suppleness, simplicity scrupulous certification, schedule appraisal, and spontaneous appraisal. Table 8.2 below presents the summary of the 11 characteristics, which the developed guidelines should meet to ensure their effectiveness.

Table 8.2: Thomas' 11 characteristics of effective guidelines development and evaluation

Characteristics	Explanations
Validity	Guidelines should be meticulously established and be reliable with the existing body of knowledge. In this study, literature was reviewed, professional experts were consulted for their inputs, and recommendations from the study participants were taken into consideration.
Cost-effectiveness	The developed guidelines are recommended for implementation by the stakeholders involved in undergraduate learner nurse training with no foreseeable costs involved.
Reproducibility	The discoveries of the present investigation were triangulated to enhance the developed guidelines. This further ensures that developed guidelines would yield similar recommendations using the same discoveries of this investigation.
Reliability	Guidelines in the present investigation were developed systematically and rigorously so that assumed the similar experimental settings; another health expert would n analogously relate the commendations.
Representative development	Guidelines development included the representations from nursing students, newly graduated professional nurses, nurse managers from the KZN health care facilities and nurse educators from both institutions under study.
Clinical applicability	The target population was defined as stakeholders intricate in learner nurses training for instance policymakers, facilitators and nurse managers.
Clinical flexibility	The human caring attributes amongst the nursing students and improvement of quality nursing care were taken into consideration to ensure that the developed guidelines were clinically flexible
Clarity	The developed guidelines were supported by rationale and recommendations for implementation to ensure clarity.
Meticulous documentation	The process of guidelines development involved the details of who participated, methods used and the recommendations were linked to the findings of the study.
Scheduled review	Professional experts in the field such as the study supervisors will review and validate the developed guidelines before they are disseminated for implementation purposes by the stakeholders in KZN health care institutions during the clinical placement of learner nurses.
Unscheduled review	Periodic modification of developed guidelines will take place during their implementation at the KZN health care institutions to incorporate new knowledge.

8.10 DISSEMINATION OF DEVELOPED GUIDELINES

It is envisaged that the developed guidelines be disseminated to the wider health care communities for its evaluation, recommendations and implementation. Developed guidelines will be disseminated in various modes such as presentation of a paper at nation-wide and global seminars, seminars, research symposiums, and published in nursing education and nursing management journals. Hard and soft copies of the thesis will be made available at the library, libraries of both institutions understudy and KZN Department of Health repository. These guidelines will also be disseminated to stakeholders such as the KZN health care institutions, nurse managers, KZN CN and DUT nursing department for reference and implementation purposes.

8.11 SUMMARY OF THE CHAPTER

This chapter presented the established clear guidelines that can be used by lecturers to enhance human caring attributes among the nursing students. These guiding principles are founded on the discoveries of the current investigation, instinctive intuition of the investigator and recommendations from scholarly work as evidenced during the literature search. The work environment must be conducive for these proposed guidelines to be effective. There is a need for all the major stakeholders in the nursing education fraternity to ensure that their employees receive the mental and physical well-being for the human caring attributes to be realised. The developed guidelines are recommended for implementation by the policymakers in KZN Department of Health, academia at both institutions understudy, nursing managers and learner nurses. Chapter 9 focuses on the supposition, recommendations and limitations of the investigation.

CHAPTER 9: CONCLUSION, COMMENDATIONS AND, LIMITATIONS, OF THE INVESTIGATION

9.1 INTRODUCTION

Chapter 8 presented the guidelines that could be used by lecturers to enhance the human caring attributes amongst the undergraduate nursing students in KZN. The results of the investigation in the form of the emerged themes, subthemes and the quantitative consequences guided the development of guidelines. The rationale and recommendations for implementations of the developed guidelines by the stakeholders involved in the student nurses' training in the in KZN health care institutions were also discussed. In this chapter, the conclusion, commendations and limits of the investigation are presented.

9.2 CONCLUSION OF THE INVESTIGATION

The investigation was steered at the dualistic organisations at the designated NEI and HEI offering the R424 undergraduate comprehensive degree and diploma as well as at the experimental healthcare institutions where these learners were allocated for their CLE in KZN. Watson's Theory of Human Caring guided the current study. Several features were identified as enhancing or hindering the development of human caring attributes from the perspective of the nursing students, neophytes (less than five years of experience) and nurse educators as well as nurse managers. The developed guidelines are intended for implementation by the nurse training institutions, healthcare institutions and policymakers in KZN Province and nurse educators.

9.3 REALISATION OF THE STUDY OBJECTIVES

The first objective of assessing the nursing students' and nursing educators' understanding of the concept human caring was realised by interviewing nursing students and newly graduated professional nurses from both institutions understudy and the focus group discussions by nurse educators and nurse managers. The first objective was also realised by answering the quantitative CBI- 42 questionnaire by nursing students and newly graduated professional nurses. The other four objectives which were to: discover and define the inherent and outside issues related to the development of human caring attributes from the perspective of the nursing students, newly graduated professional nurses and nurse educators; determine the nursing students' and newly graduated professional nurses experiences in both the theory and the clinical setting that contributed to the development of human caring attributes according to their perspective; explore and describe expertise and capabilities that are desired to be efficacious at compassionate from the perspectives of the participants and to determine the association amongst the working atmosphere and the expansion of human compassion attributes; were determined by the semi-structured interviews with the learner nurses and the newly graduated professional nurses and the focus groups discussions by the instructors and the nurse administrators. Triangulation of information from the two data sources assisted the researcher to congregate on truthful demonstration of authenticity (Polit and Beck 2017: 747). Data from two data sets were analysed thematically to reach conclusions and make recommendations.

9.4 REALISATION OF THE GOAL OF THE INVESTIGATION

The goal of the investigation was to critically analyse the part frolicked by theoretical and clinical education understandings in influencing the expansion of human caring qualities among undergraduate nursing students and newly graduated qualified nurses in KZN to establish clear guidelines that can be used by lecturers to enhance human caring attributes among the learner nurses. The goal of the present scholarship was realised by undertaking a

convergent varied technique strategy (Qualitative + Quantitative). Streubert and Carpenter (2011: 354), argued that the convergent varied technique strategy (Qualitative + Quantitative) was utilised to assess elements from both qualitative and quantitative paradigms in line for to the interactive characteristic of the scholarship. This method allowed the researcher to practice contemporary scheduling to instrument qualitative and quantitative parts throughout the similar investigation progression, prioritised both approaches in the same way, but set aside the aspects independent and only varied the quantitative and qualitative outcomes in the course of the inclusive analysis (Creswell and Creswell 2018: 217). The determination of using the convergent strategy was to acquire diverse but harmonising facts on the development of human caring attributes amongst the nursing students to empower the investigator to acquire the best possible understanding of the investigation problematic (Creswell and Creswell 2018: 216).

The quantitative results were presented in chapter 5 whilst the quantitative results were presented in Chapter 6, then the interpretation and discussion and integration of results from two data strands took place in Chapter 7, guided by the integration of Watson's theory of human caring and adult learning theories as a theoretical framework. The discoveries of the present investigation were practice to establish clear guidelines for lecturers and the clinical facilitators to be used to enhance the human caring attributes among the undergraduate nursing students in KZN as presented in Chapter 8.

9.5 RECOMMENDATIONS

The recommendations for the current study are founded on the discoveries that emanated from data analysis which led to the establishment of clear guidelines for lecturers and the clinical facilitators to be used to enhance human caring attributes among the undergraduate nursing students in KZN.

9.5.1 Recommendations for use of the developed guidelines within the KZN province

The established guidelines are recommended for all the relevant stakeholders partaking in the teaching of learner caregivers at the KZN Province for the following purposes:

- To be considered by the policymakers in the KZN Province, during their policy review period, for possible integration into the nurse training policies in this province.
- To be disseminated by the KZN Department of Health to their respective employees, after incorporating the developed guidelines in the nurse training policies.
- To be implemented by the Human Resource Managers in collaboration with nurse managers when filling the vacant positions in the health care institutions to facilitate the positive practice environment.
- To be utilised by nurse administrators when allocating and distributing professional nurses in the health care facilities to ensure reasonable nurse-patient ratios and avoiding work overload.
- The NEIs and HEIs in the KZN Province to implement the developed guidelines in the current training of the undergraduate nursing students.
- To be incorporated into the curriculum design of nurse training programmes by the NEIs and HEIs in the KZN Province in preparation for the implementation of the new Legacy Nursing Qualifications.
- To be implemented by professional nurses and operational nurse managers at the KZN health care institutions accredited for the training of undergraduate nursing students.
- To be evaluated and recommended for review considered to ensure their effectiveness in the KZN health care institutions.

9.5.2 Recommendations for future investigation

The research discoveries revealed many investigation gaps concerning the training of learner nurses in the health care institutions in KZN Province. Following areas are recommended for future research:

- The study was conducted the health care institutions and NEI/ HEIs accredited for the training of nursing students in KZN Province. It is recommended that the study be extended to other Provinces.
- The attention of the investigation was learner nurses who were studying in the four campuses of the college understudy (six campuses of the college understudy were excluded in the investigation) and one university of technology took part in the investigation (two universities offering the same programme were not included in the study. Consequently, it is suggested that all the investigation be simulated in all the campuses of the nursing college understudy and all the universities in the in KZN Province including their healthcare facilities accredited for clinical training.

9.5.3 Recommendations for CLE

- The conclusions of the current investigation necessitate the KZN health care institutional policies regarding recruitment of nurses for training, to ensure that they attract the prospective learner nurses who are fascinated in the nursing profession
- The findings of the current study also necessitate that the in KZN health policymakers need to improve their procurement procedures, to ensure that equipment and other material are available and in good working order. All equipment must be serviced timeously. The nurses must be trained as to how to use the new equipment. Maintenance department must do rounds in all the wards to check if all equipment is in good working order
- At the national and provincial levels, the administrators must formulate strategies, and policies that talk to the well-being of nurses regardless of the professional rank. This would assist in minimising the work-

related stress among the nurses and thereby improving quality patient care.

- At the district and the institutional level nurse administrators must offer the emotional and physical support for all nurse categories, to promote the mental and physical well-being of all nurses and at the same time enhance the human caring attributes amongst nurses and minimise avoidable errors.

9.5.4 Recommendations for nursing education

The commendation prepared for HEI/NEI follows hereunder:

- All HEI/NEI to assume a prospectus grounded in constructivism that encourages learner-centred coaching, knowledge and valuation approaches.
- In-service education, dialogues, discussions or conferences must be obtainable to equip instructors to use learner-focused coaching, scholarship and evaluation approach, by preparing them with group construction, acceleration expertise, team acceleration, crowd controlling and crowd changing aspects.
- All nursing education institutions to include human caring in the curriculum.
- All nursing education institutions to provide an orientation, placement and back-up course for recently employed instructors.
- Reconsider the existing recruitment method for lecturers and learner nurses to invite contenders that are fascinated in a nursing career.

9.6 IMPACT OF THE ENQUIRY TO THE EXISTING LITERATURE

Findings obtained from the study may be applied to adapt and progress the teaching and preparation of learner nurses by clinical facilitators and theory lecturers of NEI in refining and re-enforcing their coaching techniques and approaches in theory and clinical training to enhance the human caring attributes amongst undergraduate nursing students. The outcome of this

investigation may serve as a form of reference for policymakers to adapt and improve their policies relating to instruction and training of learner nurses at the HEI/NEI and resolve the trials pupil nurses come across in CLE. Findings may also form the baseline information for further research to add to the body of knowledge and training of caregivers as to how to enhance human caring attributes amongst undergraduate learner nurses. The current investigation may augment meaningfully to the health fraternity, by tackling difficulties in the working environment that impedes the effectiveness of instruction and preparation of learner nurses to increase the expansion of the human caring attributes amongst undergraduate nursing students which are future nurses and ultimately help to improve the quality of patient care and reduce the high level of lawsuits against the Department of Health.

9.7 LIMITATION OF THE INVESTIGATION

The restrictions of the current investigation follow below:

- The study focused on the learner nurses from the second level to the last level of their training, newly graduated nurses, nurse educators responsible for teaching the comprehensive course (R424) and nurse managers where these learners are placed, the findings could have been different if nursing students from all the levels of training, all professional nurses regardless of when and where they studied, nurse managers from all the healthcare facilities in the KZN province as well as all nurse educators irrespective of the course they are teaching were included in this study.
- The current study used a convergent mixed methodology design; the findings could have been different if other research methodologies were utilized.
- Learner nurses that took part in this research were studying in only four campuses of the NEI understudy and the UoT in the KZN Province, as well as only three health care institutions, were included population, the inclusion of all the campuses of the NEI understudy, entire universities offering the undergraduate nursing courses (R424) in KZN Province as

well as all the healthcare institutions where learners are located for the experiential learning might have influenced the findings otherwise.

- Several stakeholders, whose information could have enriched the findings of the study such as patients and their relatives, were not included.

9.8 FINAL CONCLUDING REMARKS

This section completes the dissertation. It presented the finish remarks, the commendations prepared and the restrictions of the investigation. The literature review confirmed that there were theory-practice gaps in the training of nursing students and that there were no developed guidelines concerning the enhancement of the human caring attributes amongst the undergraduate nursing student in the KZN Province. The research aim 'to critically analyse the role played by theoretical and clinical learning experiences in influencing the development of human caring attributes among undergraduate nursing students and neophytes (less than five years of experience) in KZN to establish clear guidelines that can be used by lecturers to enhance human caring attributes among the nursing students' was addressed. The researcher also established clear guidelines that can be used by lecturers to enhance human caring attributes among the nursing students. Commendations for application and appraisal of the efficacy for the established guidelines were suggested for upcoming investigation. Notwithstanding the acknowledged limitations for the current investigation that could yield different findings, the overall aim of the study was achieved.

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Shellenbarger, T. and Robb, M. 2015. Technology-based strategies for promoting clinical reasoning skills in nursing education. *Nurse Educator*, 40(2): 79-82.

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APPENDICES

Appendix 1: University Ethics clearance



24 June 2019

Ms N P Zikalala
54 Morcom Road
Prestbury
Pietermaritzburg
3201

Dear Ms Zikalala

Guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal.
Ethical Clearance number IREC 001/19

The Institutional Research Ethics Committee acknowledges receipt of your notification regarding the piloting of your data collection tool.

Kindly ensure that participants used for the pilot study are not part of the main study.

In addition, the IREC acknowledges receipt of your gatekeeper permission letters.

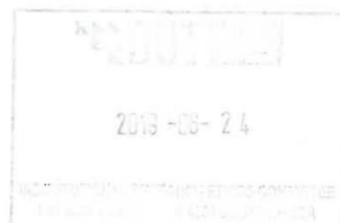
Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

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.

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely,

Professor J K Adam
Chairperson: IREC



Appendix 2a: Permission letter to the Gatekeeper Permission Committee

54 Morcom Road
Prestbury
3201

The Gatekeeper Permission Committee
Durban University of Technology
P.O Box 1334
Durban
4000

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Dear Madam

My name is Nomusa Penicca Zikalala a PhD in Health Sciences student at the Durban University of Technology. The proposed title of my study is '*Guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal*'.

I am hereby seeking your consent to conduct the research study using undergraduate nursing students and nurse educators at Indumiso Campus as participants. I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me on 073 164 1299, Email nomusaz@dut.ac.za or my supervisor Prof Sibiya on 031-373 2704 Email nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

.....
Ms Nomusa Penicca Zikalala
Durban University of Technology

Appendix 2b: Approval letter from the Gatekeeper Permission Committee



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

20th February 2019

Ms Nomusa Penicca Zikalala
c/o Department of Health Sciences
Faculty of Health Sciences
Durban University of Technology

Dear Ms Zikalala

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 and Innovation Committee (IRIC) has granted full permission for you to conduct your research "Guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal" at the Durban University of Technology.

The DUT may impose any other condition it deems appropriate in the circumstances having regard to nature and extent of access to and use of information requested.

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

Kindest regards.
Yours sincerely

PROF CARIN NAPIER
DIRECTOR (ACTING): RESEARCH AND POSTGRADUATE SUPPORT
DIRECORATE

Appendix 3a: Permission letter to the Head of Department of Nursing

54 Morcom Road
Prestbury
3201

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

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Dear Dr Ngxongo

My name is Nomusa Penicca Zikalala a PhD in Health Sciences student at the Durban University of Technology The proposed title of my study is '*Guidelines to enhance the human caring attributes amongst the undergraduate nursing students of the University of Technology in KwaZulu-Natal*'.

I hereby request for approval to conduct the research study using undergraduate nursing students and nurse educators at Indumiso Campus as participants. I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me on 073 164 1299, Email nomusaz@dut.ac.za or my supervisor Prof Sibiya on 031-373 2704 Email nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

.....
Ms Nomusa Penicca Zikalala
Durban University of Technology

Appendix 3b: Approval letter from the Head of Department of Nursing



30 July 2019

To: Ms N. Zikalala

From: Dr TSP. Ngxongo

Acting Head of Nursing Department

Faculty of Health Sciences

Durban University of Technology

PERMISSION TO COLLECT DATA AT DUT NURSING DEPARTMENT

Dear Ms Zikalala

Please be advised that your request to collect data in the Nursing Department at the DUT is approved. Please make necessary arrangement with the HoP to ensure minimal disruption of teaching and learning and for all other logistics.

Wishing you all the best with your studies and would appreciate if you could share your findings with the Department

Regards

Dr TSP. Ngxongo

Appendix 4a: Permission letter to the KZN Department of Health

54 Morcom Road
Prestbury
3201

The Health Research and Knowledge Management Component
KwaZulu-Natal Department of Health
Private Bag X9051
Pietermaritzburg
3201

Dear Dr Lutge

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Nomusa Penicca Zikalala a PhD in Health Sciences student at the Durban University of Technology The proposed title of my study is '*Guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal*'.

I hereby request for approval to conduct the research study using the comprehensive four year diploma nursing students (R425) and their facilitators at the selected nursing campuses. I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me on 0731641299, Email: nomusaz@dut.ac.za or my supervisor Prof Sibiya on 031-373 2704 Email nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

.....
Ms Nomusa Penicca Zikalala
Durban University of Technology

Appendix 4b: Approval letter from the KZN Department of Health



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

Health Research & Knowledge
Management

NHRD Ref: KZ_201906_028

Dear Ms NP Zikalala
DUT

Approval of research

1. The research proposal titled '**Guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu Natal**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Addington, Edendale, Ngwelezana and RK Khan Nursing campus as well as Estcourt, Grey's and King Edward VIII hospital.

2. You are requested to take note of the following:
 - a. Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.
 - b. Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.
 - c. Provide an interim progress report and final report (electronic and hard copies) when your research is complete to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

Date: 19/07/19

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 5a: Permission letter to the Hospital CEO

54 Morcom Road
Prestbury
3201

The Hospital CEO
UMgungundlovu District
Pietermaritzburg
3200

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Nomusa Penicca Zikalala a PhD in Health Sciences student at the Durban University of Technology The proposed title of my study is '*Guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal*'.

I hereby request for approval to conduct the research study using the comprehensive four year diploma nursing students (R425) and their facilitators at the selected nursing campuses in your district. I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me on 073 164 1299, Email nomusaz@dut.ac.za or my supervisor Prof Sibiya on 031-373 2704 Email nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

.....
Ms Nomusa Penicca Zikalala
Durban University of Technology

Appendix 5a1: Permission letter from King Edward VIII Hospital



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

OFFICE OF THE HOSPITAL CEO
KING EDWARD VIII HOSPITAL

Private Bag X02, CONGELLA 4013
Corner of Rick Turner (Francois Road) & Sydney Road
Tel: 031-3603853, Fax 031-2061457, Email: info@kznhealth.gov.za
www.kznhealth.gov.za

Ref.: KE 2/7/17 (11/2019)
Enq.: Mrs. R. Sibiyi
Research Programming

6 March 2019

Ms. NP. Zikalala
54 Morcom Road
PRESTBURY
3201

Dear Ms. Zikalala

Protocol: "Guidelines to enhance the human caring attributes among the undergraduate nursing students in KwaZulu-Natal" Ethical Clearance No. IREC 001/19

Permission to conduct research at King Edward VIII Hospital is provisionally granted, pending approval by the Provincial Health Research Committee, KZN Department of Health.

Kindly note the following:-

- The research will only commence once confirmation from the Provincial Health Research Committee in the KZN Department of Health has been received.
- Signing of an indemnity form at Room 8, CEO Complex before commencement with your study.
- King Edward VIII Hospital received full acknowledgment in the study on all Publications and reports and also kindly present a copy of the publication or report on completion.

The Management of King Edward VIII Hospital reserves the right to terminate the permission for the study should circumstances so dictate.

Yours faithfully

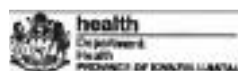
SUPPORTED/NOT SUPPORTED

DR. S. RAMJI
ACTING MEDICAL MANAGER

7/3/2019
DATE

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 5a2: Permission letter from Grey's Hospital



Private Bag X 9001, Pietermaritzburg, 3200
201 Town Bush Road, Northern Park, Pietermaritzburg, 3201
Tel: 0336973500 Fax: 0336973598

GREY'S HOSPITAL
OFFICE OF THE CEO

To:	Ms. N.P. Zikalala 54 Morcom Road, Prestbury, PMB, 3201
From:	Mrs. B.G. Anderson Acting CEO - Greys Hospital
Date:	5 March 2019
Re:	Request for permission to conduct research at Grey's Hospital: <i>Guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KZN</i>

Dear Ms. Zikalala

Your request to conduct research at Grey's Hospital refers. Permission to conduct the above study is hereby granted under the following conditions:

- Final ethics approval is a prerequisite for conducting your study at our hospital. Once obtained, please submit a copy of the full and final ethics approval;
- You are also required to obtain separate permission from the **Grey's KZNNC Campus Principal** for conducting your research there.
- You are also required to obtain approval for your study from the **Provincial Department of Health KZN Health Research Unit** prior to commencement. You will find more information at: <http://www.kznhealth.gov.za/hrkm.htm>
- Confidentiality of hospital information, including staff and patient medical and/or contact information, must be kept at all times;
- You are to ensure that your data collection process will NOT interfere with the routine services at the hospital. Focus Group Discussions (FGD) are to take place at Grey's Hospital or at Grey's Nursing College so as not to require staff to travel. Grey's Hospital can only release a maximum of **2 Unit Managers, the Nursing Manager and 1 AMN** for your FGD.
- You are to ensure that hospital resources are NOT used to manage your data collection, e.g. hospital staff collecting and/or collating data; photocopying; telephone; facsimile, etc.;
- Informed consent is to be obtained from all participants in your study, if applicable;
- Policies, guidelines and protocols of the Department of Health and Grey's Hospital must be adhered to at all times;
- Professional attitude and behaviour whilst dealing with research participants must be exhibited;
- The Department of Health, hospital and its staff will not be held responsible for any negative incidents and/or consequences, including injuries and illnesses that may be contracted on site, litigation matters, etc. that may arise as a result of your study or your presence on site;
- You are required to submit to this office a summary of study findings upon completion of your research.
- You are requested to make contact with the Nursing Manager, **Mrs. K.T. McKenzie**, at Grey's Hospital once you are ready to commence data collection.

Recommended by:

Approved by:

Dr L. Ndlovu
Senior Manager: Medical Services

Mrs. B.G. Anderson
Acting Hospital CEO

uMnyango Wezempile . Departement van Gesondheid

Fighting Disease. Fighting Poverty. Giving Hope

Appendix 5a3: Permission letter from Estcourt Hospital



Physical Address: No.1 Old Main Road , Estcourt, 3310
Postal Address : Private Bag X7058, Estcourt, 3310
Tel: 036 342 7042 Fax: 036 342 7116 Email: yvette.nunes@kznhealth.gov.za
www.kznhealth.gov.za

CEO'S OFFICE

Enquiries: Mrs. Y. Nunes
Ext: 036 342 7121/7042
21 February 2019

Ms. Nomusa Penicca Zikalala
54 Morcom Road
Prestbury

Dear Nomusa

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Request for approval to do research at Estcourt Hospital on:
Development of guidelines to enhance the human caring attributes
amongst the undergraduate nursing students in Kwa Zulu Natal is
approved.

Please ensure that you submit the approval letter and other documents
to the department of health research and ethics committee.

Thank you

Estcourt Hospital CEO

Mrs. Y. Nunes

Appendix 6a: Permission letter to the KZN College Principal

54 Morcom Road
Prestbury
3201

The Principal
KwaZulu-Natal College of Nursing
Private Bag X9089
Pietermaritzburg
3200

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Dear Dr Mthembu

My name is Nomusa Penicca Zikalala a PhD in Health Sciences student at the Durban University of Technology The proposed title of my study is '*Guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal*'.

I hereby request for approval to conduct the research study using the comprehensive four year diploma nursing students (R425) and their facilitators at the selected nursing campuses as participants. I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me on 073 164 1299, Email nomusaz@dut.ac.za or my supervisor Prof Sibiya on 031-373 2704 Email nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

.....
Ms Nomusa Penicca Zikalala
Durban University of Technology

Appendix 6b: Permission letter from KZCN Principal



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

Physical Address : 211 Pietermaritzburg Street , Pietermaritzburg 3200
Postal Address: Private Bag X 9089 Pietermaritzburg 3200
Tel: 033 264 7800 Fax: 033 394 7238 Email: sindizama.mthembu@kznhealth.gov.za
www.kznhealth.gov.za

KwaZulu-Natal College of Nursing

Reference: Mrs. S. Maharaj
Date: 12 June 2019

Principal Investigator: Nomusa Pennicca Zikalala
Durban University of Technology

**RE: GATE KEEPER PERMISSION TO CONDUCT RESEARCH AT THE KZN
COLLEGE OF NURSING CAMPUSES.**

**TITLE: Development of guidelines to enhance the human caring attributes amongst
the undergraduate nursing students in KwaZulu-Natal Province of South
Africa**

Dear Dr/Ms/Miss/Mrs. Zikalala

I have the pleasure in informing you that Gate Keeper permission has been granted to you as per the above request by the Principal of the KZN College of Nursing.

Data Collection site(s):- KZN College of Nursing Campuses

- Edendale
- RK Khan
- Addington
- Ngwelezana

Please note the following:

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research can only commence once you have received approval from the Provincial Health Research Committee in the KZN Department of Health.
3. Gate keeper permission is therefore granted for you to conduct this research at the above identified campuses after consultation with the Campus Principals.
4. The KwaZulu-Natal College and its NEI's will not be providing you with any resources for this research.
5. You will be expected to provide feedback on your findings to the Principal of the KwaZulu-Natal College of Nursing.

Thank You

*** DR. S.Z MTHEMBU
PRINCIPAL: KZN COLLEGE OF NURSING**

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 6c: Permission letter to the Campus Principal

54 Morcom Road
Prestbury
3201

The Principal
XXXX Campus
KwaZulu-Natal College of Nursing
Private Bag X9089
Pietermaritzburg
3200

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Dear Sir/ Madam

My name is Nomusa Penicca Zikalala a PhD in Health Sciences student at the Durban University of Technology. The proposed title of my study is '*Guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal*'.

I request for approval to conduct the research study using the comprehensive four year diploma nursing students (R425) and their facilitators at your campus. I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me on 073 164 1299, Email nomusaz@dut.ac.za or my supervisor Prof Sibiya on 031-373 2704 Email nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

.....
Ms Nomusa Penicca Zikalala
Durban University of Technology

Appendix 6c1: Permission letter from Ngwelezane Campus



DIRECTORATE:

NGWELEZANE NURSING CAMPUS
Private Bag X 20016, Empangeni 3880
Thanduyise Highway, Ngwelezane T/Ship
Tel.: 035 901 7094,
www.thabi.matsane@kznhealth.gov.za

KZNCN

Enquiry: Dr TE Matsane

Date: 12-08-2019

RE: Gate Keeper Permission to conduct research at Ngwelezane Campus

TITLE: Development of guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu – Natal Province of South Africa

Dear Ms/miss/Mrs. Zikalala

The above research study refers. The permission to conduct this study at Ngwelezane Campus is hereby granted to you. You are therefore; advised to adhere to the KZNCN RESEARCH POLICY with regards to this research.

Kindest Regards,

Dr TE Matsane
Campus Principal

6c2: Permission letter from Edendale Campus



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 29 Havelock Road, Pietermaritzburg, 3201
Postal Address: Private Bag X9099, Pietermaritzburg, 3200
Tel: 033-3459477/033-3927568/033-3927561 Fax: 033-33954602

Email: mona.zondi@kznhealth.gov.za
Email: deuts.zandi@kznhealth.gov.za
www.kznhealth.gov.za

KWAZULU-NATAL COLLEGE OF NURSING
EDENDALE NURSING CAMPUS (2013)

Reference: Permission Letter
Enquiries: Mrs. R.T. Zondi
Date: 09/07/2019

Principal Investigator: **Nomusa Pennica Zikalala**
Durban University of Technology
Student number: 21751706

COURSE: **PhD in Health Sciences**

RE: **Gatekeeper Permission to conduct research at Edendale Nursing Campus**

TITLE: **DEVELOPMENT OF GUIDELINES TO ENHANCE THE HUMAN CARING ATTRIBUTES AMONGST THE UNDERGRADUATE NURSING STUDENTS IN KWAZULU NATAL PROVINCE OF SOUTH AFRICA**

Dear Dr/Ms/Miss/Mrs. Zikalala

I have pleasure in informing you that Gate Keepers permission has been granted to you per above request by the Principal – Edendale Nursing Campus.

Data Collection Site: **Edendale Nursing Campus**

Please note the following:

1. Piloting of the data collection tool. Please note that this is achieved according to the first bullet of DUT Provisional approved letter.
2. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
3. This research can **only commence** once you have received approval from the provincial health research committee in the KZN Department of Health, Kwa-Zulu Natal College of Nursing and full approval from University of Natal.
4. Edendale Nursing campus will not be providing you with any resources for this research.
5. You will be expected to provide feedback on your findings (a copy of your theses) to the Principal – Edendale Nursing campus.


Thank you

MRS R.T. ZONDI
EDENDALE CAMPUS PRINCIPAL

DEPARTMENT OF HEALTH KWA ZULU-NATAL
EDENDALE NURSING CAMPUS S2013
PRINCIPAL
PRIVATE BAG 9094 29 HAVELOCK ROAD
PIETERMARITZBURG PIETERMARITZBURG
3200

Fighting Disease, Fighting Poverty, Giving Hope

6c3: Permission letter from RK Khan Campus

	health Department: Health PROVINCE OF KWAZULU-NATAL
DIRECTORATE:	
<div>Physical Address : R. K. Khan Circle, Chatsworth, 4092 Postal Address : R. K. Khan Campus, Private Bag x 004, Chatsworth, 4030 Telephone : (031) 459 6187 Fax: (031) 401 5229 Email: jaya.reddy@kznhealth.gov.za www.kznhealth.gov.za</div> <div>KwaZulu Natal College of Nursing R. K. Khan Campus</div>	
Ref: Permission letter Enquiries: Mrs. J. Reddy Date: 15 July 2019	
Principal Investigator:	Nomusa Pennica Zikalala Durban University of Technology Student no.: 21751706
COURSE:	PhD in Health Sciences
Re: Gatekeeper Permission to conduct research at R.K Khan Nursing Campus	
TITLE: DEVELOPMENT OF GUIDELINES TO ENHANCE THE HUMAN CARING ATTRIBUTES AMONGST THE UNDERGRADUATE NURSING STUDENTS IN KWAZULU NATAL PROVINCE OF SOUTH AFRICA.	
Dear Ms Zikalala	
I have pleasure in informing you that Gate Keepers permission has been granted to you per above request by the Principal – R.K Khan Nursing Campus.	
Date collection site: R.K Khan Nursing Campus	
Please note the following:	
<ol style="list-style-type: none">1. Piloting of the data collection tool. Please note that this is achieved according to the first bullet of DUT Provisional approved letter.2. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.3. This research can only commence once you have received approval from the Provincial Health Research Committee in the KZN Department of Health, KwaZulu Natal College of Nursing and full approval from University of Natal.4. R.K Khan Nursing Campus will not be providing you with any resources for this research.5. You will be expected to provide feedback on your findings (a copy of your thesis) to the Principal – R.K Khan Nursing Campus.	
Thank you [Redacted Signature]	
Mrs. J. Reddy – Campus Principal	
Fighting Disease, Fighting Poverty, Giving Hope	
<div>KZN COLLEGE OF NURSING R.K. KHAN CAMPUS 15 JUL 2019 PRIVATE BAG/PRIVAATSAK X004 CHATSWORTH 4030</div>	

6c4: Permission letter from Addington Campus



health

Department

Health

PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

15 BIRKBECK TERRACE, SOUTH BEACH, DURBAN, 4001
P.O. BOX 877, DURBAN, 4000
Tel: 031-327 2919 Fax: 031-327 2079
Email: thando.sikakane@kznhealth.gov.za
Web: www.kznhealth.gov.za

TRAINING CAMPUS ADDINGTON

Reference: Permission for research

Enquiries: TP Sikakane-Masango

29-07-2019

Ms Zikalala

PERMISSION TO CONDUCT RESEARCH AT ADDINGTON CAMPUS

Dear Ms Zikalala

Permission is hereby granted for you to conduct your research on:

"GUIDELINES TO ENHANCE THE HUMAN CARING ATTRIBUTES AMONGST THE UNDERGRADUATE NURSING STUDENTS IN KWAZULU-NATAL"

Please take cognizance of the following:

- You must adhere to all policies, procedures, protocols and guidelines of the Department regarding research
- Please inform our institution before research is commenced
- Please provide a copy of your research report to the Campus, on completion of the study

^With love and all the best for your studies

Ms. T.P. Sikakane-Masango
Campus Principal

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 7a: Request and approval to use a validated questionnaire

Dear Prof

I would like to request your permission to use the CBI -42 research tool for my study. Enclosed in this email is the request letter and the research proposal.

Kind regards

Nomusa

Appendix 7b: Permission to use the CBI Tool

Release Form
Caring Behaviors Inventory: CBI 42, 24, 16, and 6
Zane Robinson Wolf
©1981, 1994

You have my permission to use a version of the Caring Behaviors Inventory in your research or project. Completing, signing, scanning, and returning this form grants permission.

Please complete the items on the form and return by email. I am also asking your permission to share your name and email address with future colleagues interested in using a translated version of the instrument.

Name: Mrs. Nomusa Penicca Zikalala	Degrees and Certifications: M Cur Registered for the following degree: PhD in Health Sciences
Address: 54 Morcom Road, Prestbury Pietermaritzburg 3201	
Employer: Durban University of Technology	
University: Durban University of Technology	
Phone-Cell: 0731641299	Phone-Work: 033 845-9014
Phone-Home, Land: N/A	Other Phone: 033 845 9055 ext. 9014
Email Address: nomusa.Z@dut.ac.za	Second Email Address: nomusa.zikalala@vodamail.co.za

Version of the CBI that you are interested in administering:

Version	✓ Please check
CBI 42	✓
CBI 24	
CBI 16	
CBI 6	

1. Very briefly describe your use of the CBI: Title of the research study:

Guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal

The aim of the study is to analyse the role played by theoretical and clinical learning experiences in influencing the development of human caring attributes among undergraduate nursing students in KwaZulu Natal, in order to develop guidelines that could be used by lecturers to enhance human caring attributes among the nursing students.
 (Please see the proposal attached)

2. Estimate how many subjects/participants/students, etc. will be involved in your use of the CBI.
About 300 participants
3. If you translate the instrument, please identify the language of the translation: N/A. If you translate the instrument, you own the copyright and will cite the CBI research literature.
4. If your research study involves a thesis or dissertation, identify the major advisor's name and address:

Name: Prof. M.N. Sibiya	Degrees and Certifications: D Tech: Nursing
Address Executive Dean: Faculty of Health Sciences Durban University of Technology, Durban 4000	
Email: nokuthula@duet.ac.za	

5. I plan to modify the instrument; please circle: (Yes) ☒ No
6. I will translate and reverse translate the instrument; please circle: Yes ☐ (No) ☒

I will email the version that I administer to Dr. Wolf and will notify Zane Robinson Wolf when a publication results from administration of the CBI. I will send current postal and email addresses.

Signature 3 February 2019
Date

Mrs. Nomusa Penicca Zikalala
Print

Please retain one copy of this form for your records and send the original back as a scanned pdf.

Thank you for your interest in the Caring Behaviors Inventory. I own the copyright for the instrument.

Zane Robinson Wolf, PhD, RN, FAAN
27 Haverford Road
Ardmore, PA 19003 USA

Appendix 8a: Letter of information for FGDs with lecturers and nurse managers



Dear Participant

Thank you for agreeing to participate in this study.

Title of the Research Study: Development of guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal Province of South Africa.

Principal Investigator/s/researcher: Mrs NP Zikalala (PhD: Health Sciences Candidate).

Co-Investigator/s/supervisor/s: Prof MN Sibiya, (D Tech: Nursing), Prof N Jinabhai (PhD).

Brief Introduction and Purpose of the Study: I will be conducting the study regarding formulation of the guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal Province of South Africa.

Outline of the Procedures: This focus group discussion is designed to assess your current thoughts and feelings about the role played by theoretical and clinical learning experiences in influencing the development of human caring attributes among nursing students, in order to develop guidelines that can be used by lecturers to enhance human caring attributes among the nursing students. Each focus group discussion will have 4-6 participants. The focus group discussions would be held in one of the university's boardroom and college boardroom. Permission will be sought from the participants to voice record the discussions. The focus group will take approximately one hour to allow for a detailed discussion of the issues. Despite being taped, I would like to assure you that the discussion will be anonymous. The tapes will be kept safely in a locked facility until they are transcribed word for word, then they will be destroyed. The transcribed notes of the focus group will contain no information that would allow individual subjects to be linked to specific statements. You should try to answer and comment as accurately and truthfully as possible. I and the other focus group participants would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so; however please try to answer and be as involved as possible.

Risks or Discomforts to the Participant: There is no risk or discomfort that will be inflicted to the participants.

Benefits: Findings obtained from the study can be used to adapt and improve the education and training of nursing students by the clinical facilitators and theory lecturers of Nursing Education Institution in refining and re-enforcing their teaching methods and strategies in both theory and clinical education thereby enhancing the human caring attributes amongst undergraduate nursing students.

Reason/s why the Participant May Be Withdrawn from the Study: You will be allowed to opt out from the study or withdraw at any time should you wish to do so.

Remuneration: You will not be expected to pay anything for taking part in the study, and also no payment will be given to you for taking part in the study.

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

Confidentiality: All the information will be kept in strict privacy. Your name will not be written on any of the data collection tools except on the consent form which will be kept in strict privacy all the time with your responses. The information gathered will only be used for the purpose of this study.

Research-related Injury: No compensation, however the nature of the study does not pose any risk of injury to you.

Persons to Contact in the Event of Any Problems or Queries: Researcher: Mrs NP Zikalala Mobile: 0731641299; Supervisor, Prof Sibiya; Co-supervisor, Prof Jinabhai Durban University of Technology Tel: 031-373 2704, or the Institutional Research Ethics Administrator on 031-3732375. Complaints can be reported to the Director: Research and Postgraduate Support, Prof C. Napier on 031-3732577 or carinn@dut.ac.za

Appendix 8b: Letter of information for interviews with and professional nurses



Dear Participant

Thank you for agreeing to participate in this study.

Title of the Research Study: Development of guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal Province of South Africa.

Principal Investigator/s/researcher: Mrs NP Zikalala (PhD: Health Sciences Candidate).

Co-Investigator/s/supervisor/s: Prof MN Sibiya, (D Tech: Nursing), Prof N Jinabhai (PhD).

Brief Introduction and Purpose of the Study: I will be conducting the study regarding formulation of the guidelines to enhance the human caring attributes amongst the undergraduate nursing students in KwaZulu-Natal Province of South Africa.

Outline of the Procedures: Interviews would be conducted by the researcher with the help of a research assistant. The research assistant would be a Masters student who understands research methodology and is fluent in English which is the medium of instruction at the university and college under study. The interview guide contains questions addressing the main research questions. The interview guide however, would not be used as a rigid structure. Where necessary the interviewer will ask follow up questions for clarification even if they are not included in the interview guide. If issues that are not addressed in the interview guide keep coming up repeatedly during the interviews, the interview guide may be amended to include questions around these issues. The interviews will be undertaken until data saturation is reached. The researcher will request for a quiet room or space to conduct the interviews. Permission will be sought from the participants to voice record the interview discussions. Each interview session will take approximately 45 minutes to one hour to allow for a detailed discussion of the issues.

Risks or Discomforts to the Participant: There is no risk or discomfort that will be inflicted to the participants.

Benefits: Findings obtained from the study can be used to adapt and improve the education and training of nursing students by the clinical facilitators and theory lecturers of Nursing

Education Institution in refining and re-enforcing their teaching methods and strategies in both theory and clinical education thereby enhancing the human caring attributes amongst undergraduate nursing students.

Reason/s why the Participant May Be Withdrawn from the Study: You will be allowed to opt out from the study or withdraw at any time should you wish to do so.

Remuneration: You will not be expected to pay anything for taking part in the study, and also no payment will be given to you for taking part in the study.

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

Confidentiality: All the information will be kept in strict privacy. Your name will not be written on any of the data collection tools except on the consent form which will be kept in strict privacy all the time with your responses. The information gathered will only be used for the purpose of this study.

Research-related Injury: No compensation, however the nature of the study does not pose any risk of injury to you.

Persons to Contact in the Event of Any Problems or Queries: Researcher: Mrs NP Zikalala Mobile: 073 164 1299; Supervisor, Prof Sibiya; Co-supervisor, Prof Jinabhai Durban University of Technology Tel: 031-373 2704, or theInstitutionalResearchEthicsAdministratoron031-3732375.ComplaintscanbereportedtotheDirector:ResearchandPostgraduateSupport,Prof C. Napier on031-3732577orcarinn@dut.ac.za



Appendix 9: Consent

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ms N.P. Zikalala 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 Thumbprint	Date	Time	Signature / Right

I, Ms Nomusa Zikalala 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 10a: Demographic data for students and professional nurses

Please answer the following questions in the spaces provided by placing X in the most appropriate option.

PART A: DEMOGRAPHIC DATA

1.1 Race

African	
White	
Other specify	

1.2 State your age

1.3 Gender

Male	
Female	

1.4 Marital status

Single	
Married	
Divorce	
Widow/widower	
Cohabitation	

1.5 Religious practice

Christian	
Muslim	
Nazareth	
Other	

1.6 My current status is

Nursing student	
Community service nurse	
Professional nurse	

1.7 Please indicate your level of study or years of experience your current job?

<1 Year	
2 Years	
3 Years	
4 years	
5 years	

1.8 I am currently studying/ or completed my studies at the following institution:

DUT	
KZNCN	

Appendix 10b: Interview guide for students and professional nurses

PART B: QUESTIONS

1. What is the role played by theoretical and clinical learning experiences in influencing the development of human caring attributes among undergraduate DUT nursing students, in order to develop guidelines that can be used by lecturers to enhance human caring attributes among the nursing students?
2. What is your understanding of the concept human caring?
3. Briefly describe the intrinsic and extrinsic factors related to the development of human caring attributes from your perspective.
4. What are your experiences in both the theory and the clinical setting that contributed towards the development of human caring attributes according to your perspective?
5. Briefly describe skills and abilities that are needed to be successful at caring from your perspectives.
6. What is your opinion with regard to the working environment and the development of human caring attributes?
7. What would you recommend as additional measures that can be put in place to assist and support nurse educators and nursing students engaging in nursing education and training to improve the quality of patient care?

Appendix 11a: Request and approval to use a validated questionnaire

Dear Prof

I would like to request your permission to use the CBI -42 research tool for my study. Enclosed in this email is the request letter and the research proposal.

Kind regards

Nomusa

Appendix 11b: Questionnaire for students and newly graduated professional nurses

Caring Behaviour Inventory by Wolf *et al.* (1994)

Instructions

1. Please mark the correct answer by putting X in the relevant box.
2. Do not write your name in the questionnaire.
3. Please respond to all the questions.

PART A: DEMOGRAPHIC DATA

1.1 Race

African	
White	
Other specify	

1.2 State your age

1.3 Gender

Male	
Female	
Other	

1.4 Marital status

Single	
Married	
Divorce	
Widow/widower	
Cohabitation	

1.5 Religious practice

Christian	
Muslim	
Nazareth	
Other	

1.6 My current status is:

Nursing student	
Community service nurse	
Professional nurse	

1.7 Please indicate your level of study or years of experience your current job.

<1 Year	
2 Years	
3 Years	
4 years	
5 years	

1.8 I am currently studying/ or completed my studies at the following institution:

DUT	
KZNCN	

CARING BEHAVIOURS		Strongly disagree	disagree	Agree	Strongly agree
1	Attentively listening to patients				
2	Giving instructions or teaching the patients				
3	Treating the patients as individual				
4	Spending time with patient				
5	Touching the patient to communicate caring				
6	Being hopeful for the patient				
7	Giving the patient information so that he/ she can make a decision				
8	Showing respect for the patient				
9	Supporting the patient				
10	Calling the patient by his/ her preferred name				
11	Being honest with the patient				
12	Trusting the patient				
13	Being empathetic or identifying with the patient				
14	Helping the patient grow				
15	Making the patient physically or emotional comfortable				
16	Being sensitive to the patient's need				
17	Being patient or tireless with the patient				
18	Helping the patient				
19	Knowing how to administer intravenous infusion				
20	Being confident with the patient				
21	Using a soft gentle voice with the patient				
22	Demonstrating professional knowledge and skills				
23	Watching over the patient				
24	Managing equipment skilfully				
25	Being cheerful with the patient				
26	Allowing the patient to express feelings about his or her disease and treatment				
27	Including the patient in planning his or her care				
28	Treating patient information confidentially				
29	Providing a reassurance presence				
30	Returning to the patient voluntarily				
31	Talking with the patient				
32	Encouraging the patient to call if there are problems				
33	Meeting the patients' stated and unstated needs				
34	Responding quickly to the patients' call				
35	Appreciating the patient as a human being				
36	Helping to reduce the patients' pain				
37	Showing concern for the patient				
38	Giving the patients' medication on time				
39	Paying special attention to the patient				
40	Relieving the patients' symptoms				
41	Putting the patient first (patients are my priority)				
42	Giving good physical care				

Appendix 12a: Demographic data for the focus group discussions guide for lecturers and Nurse Managers

Please answer the following questions in the spaces provided by placing X in the most appropriate option.

1. Age:.....

2. Gender

Male	
Female	
Other	

3. How many years of experience have you had in this current job?

<1 Year	
1-2 Years	
2-5 Years	
5-10 Years	
>10 Years	

4. Experience in nursing profession (clinical):

1-2 Years	
2-5 Years	
5-10 Years	
>10 Years	

5. Position:

Clinical facilitator	
Junior lecturer	
Lecturer	
Senior lecturer	
Nurse mentor/preceptor	
Nurse manager	

6. My employer currently is

DUT	
KZNCN	
KZNDOH	

Thank you for taking the time to complete this questionnaire

Appendix 12b: Focus group discussion guide for lecturers and Nurse Managers

Guiding questions

- What is your understanding of the concept human caring?
- Briefly describe the intrinsic and extrinsic factors related to the development of human caring attributes from your perspective.
- What are your experiences in both the theory and the clinical setting that contributes towards the development of human caring attributes according to your perspective?
- Briefly describe skills and abilities that are needed to be successful at caring from your perspectives.
- What is your opinion with regard to the working environment and the development of human caring attributes?
- What would you recommend as additional measures that can be put in place to assist and support nurse educators and nursing students engaging in nursing education and training to improve the quality of patient care?

Appendix 13: Editing Certificate

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31 March 2020

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EDITING CERTIFICATE

**FOCUS AREA: PHD - GUIDELINES TO ENHANCE THE HUMAN CARING
ATTRIBUTES AMONGST THE UNDERGRADUATE NURSING STUDENTS IN
KWAZULU-NATAL**

We hereby certify that this document has been proofread and edited. In addition, structural suggestions have been made on the PhD thesis of Nomusa Zikalala. The thesis was edited by Dr JO Adebayo and Dr N Govender. Nomusa Zikalala is advised to read comments and suggestions and amend and attend to them accordingly before final print. Many paraphrasing issues were highlighted and require attention.

Sincerely, editors

Joseph Olusegun Adebayo, PhD.

N Govender, PhD.

Appendix 14: Turnitin Report

GUIDELINES TO ENHANCE THE HUMAN CARING ATTRIBUTES AMONGST THE UNDERGRADUATE NURSING STUDENTS IN KWAZULU-NATAL			
ORIGINALITY REPORT			
% 11	% 10	% 3	%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS
PRIMARY SOURCES			
1	repository.up.ac.za Internet Source		% 2
2	pdfs.semanticscholar.org Internet Source		% 1
3	uir.unisa.ac.za Internet Source		% 1
4	hdl.handle.net Internet Source		% 1
5	ir.dut.ac.za Internet Source		<% 1
6	open.uct.ac.za Internet Source		<% 1
7	Jamila Chellan, Nokuthula Maureen Sibiya. "Nursing staff perceptions regarding the clinical audit tool used for relicensing inspections within eThekweni private hospitals in South Africa", International Journal of Health Care Quality		<% 1