STUDENT NURSES AND EDUCATORS' EXPERIENCES OF CLINICAL TEACHING AND LEARNING DURING COVID-19 PANDEMIC IN SELECTED CAMPUSES OF GAUTENG COLLEGE OF NURSING

Zandile Goodness Malindisa

Student number: 22176162

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Supervisor: Dr D.G. Sokhela

Co-supervisor: Prof T.S.P. Ngxongo

Date: OCTOBER 2024

DECLARATION

I, Zandile Goodness Malindisa, do affirm that this is completely my own work and not anyone else's. Where the works of other authors have been used, this is appropriately referenced and acknowledged. This work has not been submitted in any form for any other degree or professional qualification to the Durban University of Technology or other institutions for examination purposes or any other purpose.

10 October 2024

Signature of student Date

Approved for final submission

16 October 2024

Dr D. G. Sokhela Date
RN, RM, D Nursing

13 0ctober 2024

Prof TSP. Ngxongo Date
RN, RM, D Nursing

DEDICATION

I DEDICATE THIS DISSERTATION TO MY HUSBAND AND MY TWO CHILDREN AND TO ALL FAMILY MEMBERS AND FRIENDS OF THE STUDENT NURSES AND EDUCATORS WHO LOST THEIR LIVES DURING THE COVID-19 PANDEMIC IN THE GAUTENG COLLEGE OF NURSING.

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My husband, Dan who was always there for me financially, and emotionally and even attended to household responsibilities on my behalf, while I was busy with my studies.

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ABSTRACT

Background

The Corona virus disease (COVID-19) pandemic, which was first reported in Wuhan in December 2019, spread to other countries in the world, including South Africa. When the infections were very high, different stages of national lockdown were put in place, to curb the rapid spread of the infection. All education institutions were closed, including Nursing Education Institutions for both theory and clinical practice. Student nurses could not practice for three months of level five lockdown. Once the infections started to subside, student nurses went back to clinical areas and some students cared for patients with COVID-19 disease, with no knowledge or adequate protection from the disease.

Aim

The study aimed to explore student nurses' and educators' experiences of clinical teaching and learning during the COVID-19 pandemic in selected campuses of the Gauteng College of Nursing.

Methods

A descriptive qualitative design was used to conduct face-to-face individual interviews with 15 purposively selected student nurses who were in their fourth-year of the R425 training programme and four clinical educators.

Findings

Three themes and 16 subthemes emerged. The themes were: clinical experiences during the COVID-19 pandemic, clinical teaching and learning during COVID-19 pandemic, and coping strategies that can be used in future pandemics or similar crises.

Conclusion

The findings from this study indicate that teaching and learning were very challenging during the COVID-19 pandemic due to the restrictive policies that were imposed in the country affecting nurse training and education.

Key words: COVID-19, personal protective equipment, clinical placement, and clinical hours.

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OPERATIONAL DEFINITIONS

TERM	MEANING
Clinical areas	Clinics and hospital wards where students are allocated to work for their experiential learning during training.
Clinical hours	A stipulated number of hours by the SANC that a student nurse has to work during clinical placement for the duration of the training course.
Clinical placement	The allocation of student nurses in clinical areas during their training.
COVID-19	An infectious disease caused by the SARS-Cov-2 virus. **"CO"** stands for corona, **"VI"** for virus, and **"D"** for the disease. **"19"** indicates the year in which it was first identified.
Health care worker	Anyone who renders a health care service including nurses, doctors, and counsellors.
Nurse educator	A professional nurse with an additional qualification to teach and prepare nurses for entry into practice positions. Nurse educator/s and lecturer/s are used interchangeably in this study.
Personal Protective Equipment	Equipment used to prevent or minimize exposure to infection.
R171 Nursing programme	A three-year diploma programme leading to registration with SANC as a general nurse.
R425 Nursing programme	A four-year diploma programme leading to registration with SANC as a general nurse, community nurse, psychiatric nurse, and midwife.
Student nurse	A student who is enrolled with a Nursing Education institution to undergo a nursing programme. Student nurses and nursing students are used interchangeably in this study.

ACRONYMS

ACRONYM	**FULL TERM**
ALC	Ann Latsky Campus
CHBC	Chris Hani Baragwanath Campus
GCON	Gauteng College of Nursing
GPRC	Gauteng Provincial Review Committee
ICN	**International Council of Nurses**
IREC	Institutional Research Ethics Committee
NEI	**Nursing Education Institution**
PPE	Personal Protective Equipment
SANC	South African Nursing Council
WHO	**World Health Organization**

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction and background

The coronavirus disease (COVID-19) was first reported in Wuhan City, China, in December 2019, and spread to other countries in the world, including South Africa (South African Government, 2020). In March 2020, the South African National Health Minister announced the first positive case of COVID-19. In response, the President Cyril Ramaphosa put South Africa on a level five lockdown, which was the most restrictive of all levels, to curb the rapid spread of Coronavirus in the country (South African Government, 2020).

During the same period, the Ministries of Basic and Higher Education, Science and Innovation closed all education institutions, including Colleges of Nursing (South African Government, 2020). This resulted in student nurses not being able to practice in the clinical areas for three months, to complete clinical hours as prescribed by the South African Nursing Council (South African Nursing Council, 1985).

When clinical placement could not take place, the SANC resolved that where simulation was used, it should be well structured and should not be more than 20% of the total clinical hours per programme (South African Nursing Council, 2020). The Gauteng College of Nursing offers two nurse-training programmes namely, a four-year diploma (R425) that requires completed 4000 hours of clinical practice spread over four academic years to qualify as a registered nurse such as general, psychiatric, community nurse, and a midwife. The other programme is a three-year diploma (R171) where a nursing student is required to complete 1970 hours of clinical practice over three academic years to qualify as a registered nurse or general nurse (South African Nursing Council, 2013). When student nurses in the R425 programme were allowed to return to the college, they were placed in clinical settings for various skills during the COVID-19 pandemic. Some of them had to care for COVID-19 patients as some units or wards were turned into COVID-19 facilities. This was a novel virus and there was insufficient information about the disease and adequate skills on how to care for patients were available initially. Only a limited number of students were allowed in the clinical areas due to restrictive regulations such as social distancing to

prevent the spread of infection.

New protocols came into play during the pandemic such as social distancing and other restrictive movement regulations, which significantly disturbed traditional educational practice. Agu *et al*. (2021:1) point out that COVID-19 affected the way things were done in all walks of life, including Nursing Education in both developed and developing countries. Furthermore, as the crisis worsened, many governments closed schools, colleges, and universities to ensure the safety of students, teachers, and the population at large. South Africa experienced the same disruptions as other countries, from the pandemic.

The Nursing Education institution is responsible for clinical placement, accompaniment, and supervision of student nurses and must keep records of clinical training. In addition, a student shall comply with all clinical requirements of the programme as determined by the SANC, including both theory and clinical requirements (South African Nursing Council, 2005). Jamshidi *et al*. (2016:1) argue that nurse training comprises both theoretical and practical training and a large part of Nursing Education is carried out in the clinical environment. Clinical education forms more than half of the formal educational courses in nursing and, therefore, is considered to be an essential and integral part of the Nursing Education programme. This is also confirmed by the SANC where the Nursing Act (Act No 33 of 2005) stipulates that the clinical hours for student nurses should not be less than 60% of the entire duration of the training course.

The closure of Nursing Education Institutions led to the discontinuation of clinical practice in hospitals for about three months. Similarly, Pokhrel and Chhetri (2020:134) point out that the COVID-19 pandemic created the largest disruption of education systems in human history, affecting nearly 1.6 billion learners in more than 200 countries. The Nursing Education Institutions had to extend the period of training by three months to meet clinical requirements for different nursing programmes. The whole programme had to shift to both theory and clinical practice to meet the training requirements of all students (SANC, 2020).

According to Akkus *et al.* (2021:1247), nurses and other health care workers experienced negative feelings such as panic, anxiety, and fear during the COVID-19 pandemic, especially during the early stages, as they did not have sufficient and factual information about the disease. In addition, they were also afraid of contracting the virus and infecting others in the process. This is aligned with Cook *et al*. (2021:2) who assert that the psychological stress experienced by staff members was related to working with poor understanding of the virus. Furthermore, the frequently changing information and guidelines about the COVID-19 protocols were another source of stress. According to Vindrolla-Padros *et al*. (2020:5), the frequently changing and inconsistent COVID-19 guidelines and policies created a degree of uncertainty and confusion in the workplace. As a result, nurses were concerned about their future, fear of losing someone dear, and fear of dying. In addition, they complained about excessive workload and long working hours with resultant fatigue and insomnia. Nurses worked in unfamiliar environments as they were sometimes redeployed to work in units other than the ones they would have worked in, under normal circumstances (Cengiz *et al.* 2021: 2006). These authors further mention that some nurses felt that they did not have adequate skills to work in those units. This situation contributed to depressive emotions as well as obsessive behaviours of the nursing staff (Cengiz *et al*. 2021:2007).

The hospitals were not adequately prepared to deal with the COVID-19 pandemic (Moyo *et al.* 2021:13), as was evident in the shortage of human and material resources such as linen, and oxygen. There was low-quality Personal Protective Equipment (PPE) or it was not available all. Continuous use of PPE gave nurses minor disorders such as rhinorrhoea and sore throat. Similarly, Cook (2021:2) found that visors and goggles were fogging, which made the staff’s vision to be impaired.

According to Moyo *et al*. (2021:10), nurses were stigmatised and isolated for working in COVID-19 units, and they were also perceived as infection risks by their colleagues and society. On the one hand, Cook *et al.* (2021:1) assert that health care workers experienced some degree of psychological distress, as they received no psychosocial support from management. On the other hand, Vindrolla-Padros *et al.* (2020:6) mention that some health care workers had access to psychological support, but not all of them benefitted as the services were only available during the day when they

were busy with their shifts, and the night staff did not benefit at all. Contrary to many negative experiences, Akkus *et al*. (2021:1248) show that there were also positive experiences and success stories from some nurses as they developed confidence and were immensely proud for saving patients' lives. Furthermore, there was a shift from the "health care team" to the "health care family" as nurses, doctors, and patients developed as sense of camaraderie. The sense of positive experiences from the nursing staff is also affirmed by Cook *et al*. (2021:1) who point out that negative feelings such as anxiety were alleviated by factors such as resilience, coping mechanisms, and organisational support. Vindrolla-Padros *et al.* (2020:6) also suggest that several health care workers called for a celebration when their patients recovered from illnesses and were discharged for home.

1.2 Problem Statement

Student nurses could not complete their clinical practice hours due to the closure of education institutions including colleges of nursing to curb the spread of infection. During the height of the COVID-19 infections, some units or wards were turned into COVID-19 facilities, thus reducing platforms for planned clinical learning experiences for which student nurses did not have the skills. The Nursing Act (No.33 of 2005) stipulates that student nurses ought to acquire practical and clinical skills competencies before registration as professional nurses. Therefore, student nurses ought to be exposed to clinical learning opportunities before they become professionals. In South Africa, when infections started to decline and the hard lockdown was eased, final-year health students could return to clinical training in small numbers and on alternate days to avoid overcrowding.

Health facilities tested students and educators for COVID-19 before entering the premises, and most of them tested negative. However, within the first week of commencing clinical practice, some contracted the COVID-19 virus. This was mainly due to incomplete or lack of Personal Protective Equipment (PPE) for student nurses. Managers in the clinical areas expected it to be provided by nursing colleges whereas colleges thought it would be provided by the facility. This uncertainty about PPE resulted in anxiety, fear of contracting the virus, and fear of dying among student nurses and educators. According to Cengiz *et al.* (2021:2007), nurses had a challenge

accessing PPE and this caused immense fear in them. They could not go to a patient without PPE for fear of contracting the virus and bringing it to their relatives at home. Akkus *et al*. (2021:1247) and Cook *et al*. (2021:8) show that nurses experienced negative feelings such as panic, anxiety, and fear during the COVID-19 pandemic, especially during the early stages as they did not have sufficient information about the disease. According to Vindrolla-Padros *et al.* (2020:5) some of the PPE was of low quality and not the appropriate size, while Akkus *et al.* (2021:1249) argue that sometimes nurses were unable to work wearing it because they were not able to perform their nursing duties effectively.

As student nurses entered the clinical facilities, they were bound to come in direct contact with infected patients during their clinical practice, and it was the same for educators. Despite the easing of lockdown regulations, infection rates were still high. The researcher was interested in exploring the experiences of student nurses and educators who returned to clinical practice during this unprecedented period.

1.3 The Aim of the Study

The study aimed to explore student nurses' and educators' experiences of clinical teaching and learning during the COVID-19 pandemic at Gauteng College of Nursing.

1.4 Research Objectives

- To describe the experiences of clinical learning by student nurses during the COVID-19 pandemic.
- To explore the experiences of clinical teaching by nursing educators during the COVID-19 pandemic.
- To describe strategies that might mitigate the experiences of clinical teaching and learning during a pandemic or any similar crises.

1.5 Research Questions

- What were the experiences of clinical learning by student nurses during the COVID-19 pandemic?
- What were the experiences of clinical teaching by nursing educators during the COVID-19 pandemic?

- What are strategies that might mitigate the experiences of clinical teaching and learning during a pandemic or any similar crises?

1.6 Significance of the Study

The significance of the study is that experiences of clinical training and accompaniment by student nurses and educators during the COVID-19 pandemic might assist in planning for future pandemics or other similar crises.

1.6.1 The South African Nursing Council

Findings from the study can be applied by the SANC as they prepare policies that would be used by nursing training institutions during challenging times of pandemics or any crises that may arise and affect nurse training.

1.6.2 Clinical Nurse Educators

Clinical nurse educators could include innovative strategies of clinical teaching and learning during curriculum development using their experiences during the Covid-19 pandemic.

1.6.3 Student Nurses

Findings of the study might help future student nurses on how to deal with crises situations during clinical practice.

1.7 Research Method

Design

An exploratory-descriptive qualitative research design was utilized to explore experiences of clinical teaching and learning by student nurses and clinical educators in a College of Nursing in Gauteng during the COVID-19 pandemic. According to Nassaji (2020:1), qualitative research can be broadly defined as a kind of inquiry that is naturalistic and which deals with non-numerical data and seeks to understand and explore rather than explain and manipulate variables. Furthermore, qualitative research is contextualized and interpretive, emphasizing the process or patterns of development rather than the product or outcome of the research. On the one hand, Polit and Beck (2018:289) maintain that exploratory-descriptive qualitative research is

designed to illuminate how a phenomenon is manifested, making it especially useful for uncovering the full nature of a little-understood phenomenon. Furthermore, this approach is valuable when the research aims to explore new areas or understand phenomena in-depth without preconceived notions.

Sampling

The researcher purposively sampled two campuses in Johannesburg and student nurses who were in the R425 nursing programme, and who had experienced clinical placement during the COVID-19 pandemic.

Data collection

Data were collected using face-to-face individual semi-structured interviews with both student nurses and clinical nurse educators. Data were analysed following the eight steps of data analysis, from preparation to coding and codes were reviewed to eliminate redundancy, and then grouped into themes, which were arrayed into a conceptual map from a more general picture to a more specific picture. Finally, a narrative of each theme was supported by verbatim quotes in the findings section of the study and finally the discussion of overall findings was presented.

1.8 Chapter Summary

This chapter presented the background, context, and aim of the study. Furthermore, it made known the research questions, the objectives as well as the significance of the study. In the next chapter, the relevant literature will be reviewed to gain insight and a deeper understanding of the lived experiences of student nurses and clinical educators in clinical placement, during the COVID-19 pandemic.

1.9 Structure of the dissertation

Chapter	Title	Content
Chapter One	Overview of the Study	Background and introduction of the study. The researcher discusses the problem statement, aim, objectives, and significance of the study.
Chapter Two	Literature Review	The global, regional, and local literature on the research question is discussed. A Theoretical Framework that guided the study is also presented.
Chapter Three	Research Methodology	A detailed description of the methodology that guided the study is discussed. The research design, study setting, recruitment of the study population, sampling strategy, sample size, data collection, data analysis, data management and storage, and ethical considerations are presented.
Chapter Four	Presentation of Findings	In this chapter, the findings of the study from collected data are presented.
Chapter Five	Discussion of Findings, Limitations, and Recommendations	This chapter consists of a discussion of the study findings and is supported by relevant literature.
Chapter Six	Summary of Findings, Recommendations, and Conclusion	This chapter presents the summary of the findings of the study and outlines the recommendations that emanated from the findings. Limitations of the study and the conclusion are discussed.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter presents a literature review on the topic of the study, which includes a critical review of the current literature about the experiences of nurses and educators in clinical placement during the pandemic. According to Polit and Beck (2018:107), the primary purpose of a literature review is to summarize evidence on a topic. In other words, what is known and what is unknown about a study's topic. On the one hand, Creswell and Creswell (2018:72) state that the literature review shares the results with the reader of other research studies that are closely related to the one that is being undertaken. To conduct this literature review, the researcher utilized various sources of information that were accessed through a variety of databases such as Google Scholar, PubMed, textbooks, internet sources as well academic journals. The literature review assisted the researcher to identify some knowledge gaps that exist in the field and the current knowledge about the subject at hand.

2.2 The Global context of clinical placement of student nurses during the COVID-19 pandemic

The COVID-19 pandemic affected the whole globe immensely and due to the outbreak, governments throughout the world had to implement self-isolation, social distancing, and travel restrictions to contain the spread of the virus (WHO 2020:1).

2.2.1 Closure of Education Institutions

The effect of the restrictions on student nurses and their clinical educators was a different experience from what they knew as normal before the pandemic. In Bhutan South Asia, Pokhrel and Chhetri (2021:134) found that the COVID-19 pandemic created the largest disruption in education systems in human history, where educational institutions had to be closed for fear of the spread of the virus. The International Council of Nurses (ICN) (2021: 2) concurs that there were large disruptions with the extents varying widely from country to country. Therefore, Nursing Education was no exception. Furthermore, the pandemic and its rapid spread caught the whole world off guard. In addition, the ICN (2020:3) expressed their concern that the prolonged disruption in Nursing Education could negatively affect the flow of new

nurse graduates to the nursing profession, and as a result, they would not be available to join the health care services. Similarly, Agu *et al*. (2020:5) state that the impact of the COVID-19 pandemic might be greater in developing countries than in developed countries, due to disparities. Social distancing and restrictive policies significantly disturbed the traditional practices where people were no longer allowed to gather in large numbers and had to leave a space of 1.5 to 2 metres in between them to prevent the spread of infection (Pokhrel and Chhetri 2021:134). In addition, Dziurka *et al.* (2022:9) assert that when students were on national lockdown, they experienced isolation and loneliness as they had no contact with their peers while feelings of isolation and loneliness came about when an individual contracted the infection and had to be on quarantine.

In a study conducted in Spain by Alcalá-Albert *et al.* (2022:1), it was found that the COVID-19 pandemic affected many areas of life including student nurses. Furthermore, clinical learning of students was faced with a lot of challenges as clinical settings changed during the pandemic. Nursing schools had a responsibility to ensure that structures were in place to facilitate coping in the changed clinical settings. These authors further argue that clinical practice is a very critical, yet very complex and challenging component of professional development for student nurses because their professional performances are highly dependent on it. Furthermore, the quality of clinical training is very crucial for Nursing Education. Under normal circumstances, being in the clinical setting is stressful for student nurses because they are still unsure of what is expected of them (Alcalá-Albert *et al*. 2022:1).

2.2.2 Fear of contracting the virus and lack of PPE

The effect of the COVID-19 pandemic was worse among student nurses as they experienced additional stress and new challenges that were presented by the pandemic. For example, they were afraid of becoming infected with the virus and also were afraid of infecting their close family members. This is in line with the study that was conducted in Belgium by Ulenaers *et al.* (2021:1) where they argue that clinical placement can be a challenging part of training for student nurses, even without the additional challenges of a pandemic.

Xu *et al*. (2021:5) assert that, in the face of unknown epidemics, clinical student nurses had acute psychological reactions such as fear, and worry about being infected with the disease. According to Barisone *et al.* (2022:5) during the first days of clinical placement, the feelings of students included anxiety and fear of becoming infected with the virus and transmitting the disease to their families. Similarly, Ulenaers *et al.* (2021:1) argue that student nurses expressed fear and anxiety about getting infected with the virus in the clinical areas; it became worse when they found themselves in the care of COVID-19 patients. Dewart *et al.* (2020:1) point out that when student nurses were exposed to the COVID-19 infection, while in a clinical setting, they risked not only their health but that of their family at home. Furthermore, fear was intensified by insufficient PPE, and this raised questions about the responsibilities of the nursing school to keep their students safe. According to Ulenaers *et al*. (2021:4), an important stressor for students was the availability as well as the use of PPE. Student nurses needed additional training on the use of PPE, regarding donning and doffing skills that they did not have. Student nurses found themselves using the same PPE for many days, such as surgical masks and they relied on their nursing school to guarantee their safety during clinical placement. Therefore, students felt that nursing schools had to check if they had adequate PPE and if necessary, provide it (Ulenaers *et al*. 2021:4). While some student nurses were well protected in some units, others felt exposed to infection because they were not protected where they were placed. Student nurses felt that PPE limited their contact with patients. One such example is the masks which made communication very difficult as the speech was muffled, and patients could not read their lips (Dziurka *et al.* 2022:10 and Goldbold *et al.* 2021:5).

According to Ulenaers *et al*. (2021:5), student nurses made efforts to spend time with patients since they were not allowed visitors, but contact became very impersonal due to restrictive practices such as social distancing and the use of masks that hid their facial expressions. The findings of the study that was conducted in Turkey by Pazar and Savas (2023:94) confirm that student nurses had a fear of getting infected and infecting their elderly family members. Similarly, Akay and Kadiroğlu (2021:2) state that the biggest reason for their fear of being infected was not of being exposed to the virus themselves, but of infecting their families or those with whom they had close relationships. Some students feared more for their family members than catching the

infection themselves. Dziurka *et al.* (2022:9) state that when some students' family members contracted COVID-19, they often felt guilty that they could be the ones who brought the infection home to them. The clinical areas were perceived as dangerous by students, besides the fear of being infected with the virus, they also felt inadequate because they did not have sufficient knowledge about the disease, and they lacked the skills on how to care for patients with COVID-19 (Alcalá-Albert *et al*. 2022:5).

Similarly, Özdemir, Ünal and Şanlan (2023:550) point out that students experienced fear, anxiety, and hopelessness due to the uncertainty of the disease process and also because even when they had taken the required precautions, they experienced fear, and sadness at the clinical areas and they described the clinical setting as unsafe and dangerous. Ulenaers *et al.* (2021:4) mention that some students described the clinical placement during the pandemic as hectic, difficult, emotional, psychologically stressful, weird, and overwhelming. Furthermore, some students felt comfortable when the nursing school made the decision not to let them care for COVID-19 patients. Similarly, Shun (2021:1) argues that student nurses perceived clinical nursing work as "too dangerous to engage in" during the COVID-19 pandemic, with some even expressing intention to leave the nursing profession. Furthermore, the PPE that was inappropriate and uncomfortable compounded the situation and caused them to feel exhausted more easily (Cengiz *et al.* 2021:2007).

In Turkey, student nurses were made to sign contracts assuming responsibility if they contracted the COVID-19 virus at the clinics they visited during the pandemic. The signing of the contracts made them perceive themselves as victims (Özdemir, Ünal and Sanlam 2023:550). According to Alcalá-Albert *et al.* (2022:1), student nurses had to learn to "work" with fear and uncertainty and they also had to learn to self-manage the emotional burden they had, using various coping techniques to deal with learning during their clinical practice. However, Pazar and Savas (2023:91) assert that students' fear and anxiety subsided when they understood the need and the importance of providing care and thinking more for the patients instead of themselves. As much as clinical training was stressful, students also expressed feelings of calm and tranquillity as they gained more insight, knowledge, and experience on how to take care of patients. Furthermore, some patients were dying and it traumatised students as they had bonded with them due to their long stay in the

units (Alcalá-Albert *et al.* 2022:6). Dziurka *et al* (2022:10) concur that when students noticed that the patients they had been caring for had died, they became more stressed.

2.2.3 Cancellation of Classes

Student nurses go to clinical areas to practice what they have been taught in class, that is "to put theory into practice". According to Dziurka *et al.* (2022:9), students went to clinical areas but classes were often cancelled whenever COVID-19 was detected in a student group or among patients and staff. This made it virtually impossible for the students to acquire practical skills in clinical settings. Consequently, they ended up being dissatisfied and frustrated. Furthermore, when students did not know whether they would have classes the following day, they found themselves in a state of chaos and confusion. Dziurka *et al.* (2022:8) and Dewart *et al.* (2020:1) further point out that since classes were frequently cancelled or not scheduled at all, students would wonder if they would complete their training and graduate, or their graduation would be postponed.

Furthermore, students expressed their fear that cancellation of their practical classes during their training would affect their future work where they would not be well equipped and would still need to learn more practical skills from their colleagues at work, after being employed as qualified nurses. Similarly, Dewart *et al.* (2020:1) highlight the very same challenge in their study that student nurses expressed concern about what the interruption in their Nursing Education would mean for their future careers as registered nurses. Many students had concerns about progressing in the rest of their training programme.

According to Ulenaers *et al.* (2021:4), students expressed that there were fewer learning opportunities for them as their preceptors did not monitor them sufficiently. As a result, there were competencies that students could not attain easily due to lack of supervision. Additionally, some students verbalised that there were little to no opportunities for them to practice technical nursing skills. Relating to learning opportunities, Dziurka *et al.* (2022:8) highlight that students were concerned with the methods of conducting practical classes in a situation where they could not be held in clinical settings. Furthermore, students, in their opinion, felt that replacing practical

classes with procedures or nursing processes developed for such purpose, would not compensate for real-life work in a healthcare facility. Therefore, students were not certain if they would be able to render safe patient care under such conditions. Students experienced stress, anxiety, emotional exhaustion, and depression which led to lower caring capacity and poor quality of patient care. Similarly, Özdemir, Ünal and Şanlan (2023:552) found that lack of clinical placement due to the pandemic made students feel inadequate, while Ulenaers *et al.* (2021:1) argue that preparing students for specific competencies is needed, however students got lost in the chaos of the pandemic. This resulted in practical worries, fewer learning opportunities, and even fundamental doubts about the choice to become a nurse. Furthermore, Thomas *et al* (2023:125) state that in response to this new hospital climate, many academic institutions chose to delay or cancel their students' clinical placements, thereby limiting their students' exposure to direct clinical care.

According to Shun (2021:1), the student nurses perceived clinical nursing work as "too dangerous to engage in" during the COVID-19 pandemic, and some even expressed the intention to leave the nursing profession. Additionally, the impact of the COVID-19 pandemic put healthcare providers under additional stress both in terms of mental and physical workload. Students were confronted with an increased workload and uncertainties caused by the pandemic, which restricted hospital staff from supervising them. Some students started to have doubts about the continuation of the training programme. Pazar and Savas (2023:91), assert that students had both positive and negative thoughts about the nursing profession. While some student nurses thought that nursing was a sacred profession, others thought that the profession was not well or sufficiently appreciated by people.

Susmarini *et al.* (2022:180) point out that during the pandemic, students felt that the achievement of clinical competence was not optimal because some hospitals regulated practice hours and reduced student numbers for their safety and that of the patients. Furthermore, some students complained about clinical schedule changes and erratic ward relocations accompanied by different rules in each practice room. Additionally, when students tested positive for COVID-19 and were in isolation, the whole process interfered with their clinical training as they had to be isolated for 14

days. Dziurka *et al*. (2022:14) mention that some students felt disappointed about the absence of practical activities because they thought this could affect their future careers.

2.2.4 Lack of Clinical and Psychological Support

There were difficulties in co-operation between students in clinical settings and nurses employed in the wards during the COVID-19 pandemic. Nobody was prepared to listen to students' queries; they were not given attention and they lacked supervision from nurses in the ward who were not willing to act as their teachers. Yet at the same time, they had to nurse COVID-infected patients who were very sick (Dziurka *et al*. 2022:14). There was a belief among nurses that it was the sole responsibility of a dedicated mentor or a head nurse to teach students.

Regarding communication between students and the clinical site staff, Ulenaers *et al.* (2021:4) argue that poor communication was said to be one major problem experienced by students. They felt that there was a lack of openness as they found themselves excluded from meetings and were not informed about infected patients or staff members. Students were discriminated against where services such as testing for COVID-19, and psychological assistance or support did not always include them but permanent staff only. Dziurka *et al*. (2022:8) also allude to the discrimination of students where they felt abandoned and missed contact with their clinical educators. Similarly, some students felt a lack of acceptance and support from the medical personnel in the clinical setting where their clinical training was taking place. Ulenaers *et al*. (2021:5) highlight that students need to be heard, prepared, and supported. Many students indicated that they needed more psychosocial support and more contact with their clinical placement supervisors, regarding acknowledgements that the clinical learning was occurring under difficult conditions. Therefore, they needed space to unwind. On the one hand, nurses could not provide appropriate supervision to the students due to their insecurity, due to the pandemic, and shifting from one unit to the other made it more difficult for them to support students in their learning process. On the other hand, students had mixed feelings about communication and teamwork. While some felt that they were negatively affected by the pandemic, others experienced better and improved communication and teamwork during the pandemic.

Similarly, Pazar and Savas (2023:94) and Shun (2021:1) state that students experienced negative emotions such as fear and high levels of emotional stress during the COVID-19 pandemic. Further, they also felt useful and had positive experiences in terms of clinical learning. Students who had support from their family members and friends experienced less fear of the COVID-19 pandemic (Pazar and Savas 2023:94).

2.2.5 Coping with the Pandemic

Students had to ensure that they were protected from contracting the COVID virus, by boosting their immune systems through eating nutritious diets. However, they needed money to achieve a healthy diet as this increased their daily expenses (Susmarini *et al.* 2022: 180). According to Barisone *et al.* (2022:5), participants described how crucial non-verbal communication was for them when connecting with the patients. Furthermore, patient relationships, non-verbal language together with technical skills were some of the aspects that student nurses practiced during their COVID-19 clinical experiences that made them cope with the situation. According to Ulenaers *et al.* (2021:9), the fear of COVID-19 infection was very high before the vaccine was developed. When vaccines were made available, students started feeling protected to some extent. Some students expressed that they felt happy to come in contact with patients for longer periods and they were also proud to be able to test their competencies, in real-life conditions. Some students stressed that their attitude towards the nursing profession did not change. When they experienced various challenging situations during clinical placement, they realised what kind of nurses they wanted to be and how they could approach patients and their families (Dziurka *et al.* 2022:13).

Sharing experiences with their loved ones helped many students to feel relieved. This was one of their support tools and others looked for that support from their colleagues. Student nurses disconnected from the clinical setting soon after completing the shift, by spending time with their friends. On the one hand, others sought counselling which helped them to better manage stress and anxiety (Alcalá-Albert *et al.* 2022:8). On the other hand, it was also gratifying for students when their patients recovered from the disease.

2.2.6. Responsibilities of Nursing Schools

Nursing schools were expected to provide structured and unambiguous information about learning objectives and safety measures timeously, though such exceptional and uncertain circumstances did not allow that to happen. At the same time, nursing schools and clinical sites are needed to enable students to provide safe patient care. In line with this concept, nursing schools played an active role in ensuring the personal safety of their students within the classroom and at clinical sites. During this time, nurse educators had an opportunity to build new approaches and adapt their educational approaches to train student nurses on how they could deal with their emotions and thoughts in future pandemics (Ulenaers *et al*. 2021 and Alcalá-Albert *et al.* 2022:4). Pazar and Savas (2023:1) stress the importance of collaboration between the training institution, and the clinical setting, which is the hospital.

In addition, Dziurka*, et al* (2022:8) suggest that higher education institutions should implement clear strategies to support students in terms of psychological support and compensation of nursing professional skills which might have been very limited during the COVID-19 pandemic. Furthermore, modern technology such as medical simulations, virtual reality, artificial intelligence, and telemedicine ought to be utilised in the practical teaching of student nurses. Similarly, Hargreaves *et al*. (2021:7) stress that clinical settings that incorporate telenursing will help prepare students for the future of nursing. Moreover, they believe that when the epidemic ends, students will become competent in hands-on skills as they return to clinical settings or when they are employed as registered nurses.

Lira *et al*. (2020:4) state that amid the crisis caused by the pandemic, it has become a challenge to continue planning for such an uncertain future. However, educational institutions and educators have obligations to society to think long-term about issues that relate to how to recover from the COVID-19 pandemic, while keeping the quality and clinical practice safe in the training of the students. This would help them cope with difficult new situations and it would also help them build decision skills and eventually solve problems.

2.3 The regional context of clinical placement of student nurses during the COVID-19 pandemic

Like the rest of the world, when the COVID-19 pandemic was at its highest levels, countries went on national lockdown. According to Mpasa *et al.* (2021:31), when the Malawian government lifted the lockdown regulations, Mzuzu University redeployed its student nurses back to clinical areas for clinical practice.

2.3.1 Clinical Placement After National Lockdown

During this time, all the necessary supplies such as complete PPE, disposable aprons, sanitizers, gloves, and surgical masks were provided to the students. Each nursing student was required to procure a scrub suit to be used in clinical practice (Mpasa *et al.* 2021:31). Furthermore, these students were not only issued with PPE, but one of the lecturers took them through a one-hour orientation programme on preventive measures to be followed while in the clinical area. On the contrary, in Malawi, research evidence shows that student nurses faced challenges in the clinical setting long before the emergence of the COVID-19 pandemic (Mpasa *et al.* 2021:32; Baluwa *et al.* 2021:1390). Student nurses were used as a workforce because of a shortage of qualified nursing staff, there was also a gross lack of equipment and supplies such as ventilators. In other words, the resources were severely restricted. This is evidenced by the fact that student nurses mostly utilized improvised equipment to perform nursing procedures, which compromised the quality of their clinical learning (Baluwa *et al.* 2021:1390).

2.3.2 Fear of Contracting the Virus

According to Mpasa *et al.* (2021:35), when participants were asked about fears related to the clinical environment they were allocated to, they narrated that the shortage of PPE and supplies in the clinical area brought a lot of fear. Furthermore, apart from inadequate and inappropriate PPE, such as the use of low-quality surgical masks instead of N95 masks, inadequate PPE put students at risk of contracting the virus and, this was a source of anxiety and stress for the students. Baluwa *et al.* (2021:1389) confirm these experiences and state that student nurses naturally faced a myriad of challenges in the clinical learning environment, which was more stressful than the theoretical aspect of training. Moderate-to-severe stress symptoms of anxiety

and depression were reported during the pandemic in Malawi. In Lesotho, Nyangu and Rathobei (2021:7) had similar findings where respondents expressed inadequate PPE in the clinical areas, and it brought a lot of fear to the student nurses.

According to Mpasa *et al.* (2021:36) and Baluwa *et al.* (2021:1390) the participants feared contracting and transmitting the virus to others because COVID-19 was a highly contagious disease. COVID-19 was a new infection that had just emerged and research on the disease was at its infancy, and this brought more fear to the participants since not much was known about it. Furthermore, students feared that if they contracted COVID-19, they would be put on quarantine and their learning could have been put on hold. The narrative also indicated that participants had fears that if they were infected with COVID-19, they might die and not accomplish their life goals (Baluwa *et al*. 2021:1390). Clinical experience for students during the pandemic was often described as unsafe, overwhelming, and psychologically stressful. Furthermore, Mpasa *et al.* (2021: 36) highlight that some participants expressed that the orientation they were given regarding the disease was inadequate; hence, they had fear because they did not know how to protect themselves as they provided care to the patients in the wards. However, Nyangu and Rathobei (2021:7) have a contrasting view in the sense that in their study, the respondents perceived that COVID-19 prevention protocols were adequate in the clinical facility. Furthermore, the majority of respondents had positive perceptions of their skills and knowledge to prevent COVID-19 in the simulation laboratory.

2.3.3 Fear of Rejection by the Community

Students feared rejection by their communities, particularly in the transport that drove people to workplaces. According to Mpasa *et al.* (2021:36) another fear that the students had was being isolated from and rejected by the community. They verbalized that most transporters had fears about transporting healthcare workers because they were afraid that they might transmit the virus to them from the hospital. This created fear among the students as they were unsure of the next action that their neighbours could take against them, as they were aware that the students were potentially high-risk carriers of the virus. Some of the taxi drivers even refused to take them to their various clinical practice areas for fear of contracting the virus (Mpasa *et al.* 2021:36).

2.3.4 Fear of Not Achieving Their Learning Outcomes

There was fear of not achieving their learning outcomes if student nurses contracted the infection, as they could not continue with their clinical practice during illness (Mpasa *et al.* 2021:37). Furthermore, students were not sure of who was going to support them while in the clinical area as they were not certain of faculty members and clinical staff being able to supervise and teach them. The COVID-19 pandemic forced the hospital management to reduce staffing levels as some were allocated to COVID-19 isolation centres, while faculty member visits were also uncertain. Student nurses might not learn adequately and achieve their required objectives if lecturers do not supervise them frequently in the clinical areas. This is contrary to Nyangu and Rathobei (2021:8) who maintain that clinical instructors were available and competent during the pandemic. They were teaching effectively either in the simulation laboratory or clinical areas and students were able to perform and return demonstrations in the simulation laboratory or clinical areas.

2.3.5 Inadequate Number of Patients in the Wards

The other challenge that students faced was the fewer number of patients in the ward, for student nurses to practice their nursing skills. In Malawi, there were fewer numbers of patients in hospitals during the first wave of COVID-19, and this was related to strict measures on admission procedures, which focused on emergencies only (Mpasa *et al.* 2021:37). Furthermore, without an adequate number of patients in the hospitals, student nurses were unable to achieve their clinical learning objectives to gain the required skills. This is in contrast to a study that was conducted in Ghana, where the situation was the opposite. Learning opportunities were lacking in both studies but the challenges were different. The challenge of overcrowding in the wards made it difficult for both clinical supervisors and students to have a meaningful engagement (Ziba *et al.* 2021:2). This means that students did not have optimum learning opportunities during clinical placement either because of fewer patients or overcrowding.

2.3.6 Lack of learning opportunities in the clinical areas

According to Mbakaya *et al.* (2020:7), student nurses' expectations in the wards were not always realistic, regarding the availability of clinical instructors. Students

unanimously reported that they wished for their lecturers to accompany them to the clinical areas. They valued their presence in the first days of their allocation to assist with the familiarisation with the new environment. They further wished for the presence of qualified nurses, who were often busy supervising, mentoring, and evaluating their daily clinical engagements. An increased number of students in each ward from different institutions decreased practical opportunities (Mbakaya *et al* .2020:8). This corroborates the findings by Mpasa *et al*. (2021:37), where there were very few patients admitted to the hospital and students ended up not being able to do all the procedures that they were expected to do because of inadequate patients. Although a good relationship between students from these training institutions was generally reported, students were uncomfortable with having high numbers of counterparts from various institutions in the same ward. Having large numbers resulted in fighting over patients (Mbakaya *et al.* 2020:8).

2.3.7 Alternative Teaching and Learning Approach

In Namibia, Ipinge and Batholmeus (2020:541) explored the perceptions of students regarding Work Integrated Learning (WIL) readiness from an offline and online simulation course, before and during the COVID-19 pandemic. They found that higher education institutions and educators had a responsibility to develop educational technologies both online and offline that would drive knowledge and skills acquisition. Furthermore, this educational technology would create a conducive learning environment, which would be easily adjustable to the change that was brought about by the COVID-19 pandemic (Ipinge and Batholmeus 2020:541).

2.3.8 Coping Skills During the COVID-19 Pandemic

According to Baluwa *et al.* (2021:1392), students felt encouraged when they heard and saw that the number of deaths due to COVID-19 was decreasing. This decline gave them hope to continue caring for patients. They were young, and their bodies could fight the coronavirus and recover well if they became infected during clinical practice. These authors further state that students were actively looking for up-to-date information on protecting themselves from the virus and having a positive outlook on life helped them to cope. Furthermore, they stressed the importance of religion,

amongst other things, putting their trust in God to protect them from the COVID-19 virus.

2.4 The local context of clinical placement of student nurses during the COVID-19 pandemic

South Africa, like the rest of the world, was caught off guard by the virus, and emergency measures had to be put in place to lower the rate of infections (Steenkamp and Chipps 2023:1). Student nurses could not go to clinical practice during the high levels of lockdown, yet they had clinical learning requirements and hours to fulfil. Student nurses were allowed to return in a phased manner to clinical skills laboratories on campus and clinical placement facilities when the lockdown was eased (Steenkamp and Chipps 2023:1).

2.4.1 COVID-19 Orientation Programme

Steenkamp and Chipps (2023:1) at the time of the return of student nurses and educators to clinical facilities, posit that COVID-19 was an unknown condition, with reports of uncertainties around the impact of the pandemic and mixed information on safety requirements. In preparing the students for working in healthcare facilities, an intensive orientation programme was conducted. This programme was on the information related to COVID-19, infection prevention and control, and distribution of personal PPE for social and emotional support. However, according to Jarvis *et al.* (2021:8), some participants reported being ill-equipped with the required knowledge and training in infection control measures. Furthermore, some participants reported that they anticipated that the clinical setting was now a changed, unknown environment. In addition to that, they were no longer certain about what to expect. Those perceptions resulted in anticipation of a stressful return, filled with anxiety and fear of the COVID-19 pandemic. When students returned to the clinical areas, they lacked clinical experience as they had been away from clinical placements for an extended period (Apolinaro and Moagi 2023:3). According to Jarvis *et al.* (2021:8), during the pandemic, when student nurses returned to the clinical setting, they faced a new unknown scenario which was filled with uncertainties and fears from patients and healthcare workers alike.

2.4.2 Fear of Contracting COVID-19 Virus

Just like student nurses worldwide, South African student nurses had fears about the virus. Jarvis *et al.* (2021: 4) point out that their participants' primary appraisal of returning to the clinical practice was described as being uncertain about this new unknown threat and having inadequate knowledge about the SARS-CoV-2. These authors go on to state that the participants expressed perceptions of fear and anxiety which were related to the clinical settings. Furthermore, the clinical setting was now perceived as very dangerous due to fears about being infected and in some cases, the anxiety was expressed through physiological responses. For example, some students experienced palpitations and nausea, which was due to anxiety. Students were uncertain about what to expect in the clinical settings and were, therefore, feeling stressed out, scared and anxious, and they had concerns about PPE which compromised their safety as well as the safety of their family members.

Again, Jarvis *et al.* (2021: 6) mention that several participants highlighted the role that was played by the media in influencing their perceptions. These participants perceived the reports from the media as increasing their anxiety and fear about COVID-19 in the clinical areas. According to Makhado *et al.* (2022:6), most of the student nurses described the negative impact of the COVID-19 pandemic as detrimental to their mental health. Some students verbalized that they were always scared of contracting the disease while on practicals, and they even feared losing their academic work.

2.4.3 Lack of Support from Lecturers

Many students expressed that they were not supported by their lecturers in the clinical areas. According to Makhado *et al.* (2022: 6), poor communication was a major problem that was highlighted by students. They expressed their frustrations related to poor communication from the lecturers. Similarly, Zulu, Du Plessis and Koen (2021:7) refer to the same idea that participants experienced a lack of support and supervision from their clinical educators during clinical placements. Furthermore, student nurses expressed concerns that when they were placed in the clinical areas, their educators failed to either call or visit them to check on their progress. Students even verbalised the need to be supported and supervised by clinical tutors so that they would be able to achieve their educational goals. According to Zulu, Du Plessis and Koen (2021:6),

several staff members at clinics were unsupportive. For example, some students highlighted that the professional nurses treated the students as if they were not competent and the professional nurses were not always available to the students whenever they needed to be orientated, guided and assisted. On the contrary, there were those students who expressed that supportive relationships from their educators boosted their confidence and increased their ability to cope during clinical practice (Zulu, Du Plessis and Koen, 2021:8).

2.4.4 Lack of Clinical Learning Opportunities

Student nurses' lack of clinical learning opportunities resulted in negative emotional experiences (Motsaanaka *et al*. 2020:4). In South Africa, this became a challenge during the pandemic where social distancing was emphasized therefore limiting a large number of students from learning, to prevent the spread of infection. This is in line with Apolinaro and Moagi (2023:3) who found that Nursing Education facilities implemented restrictions on students, to reduce the risk of COVID-19 transmission. Furthermore, students were concerned that they lacked clinical hours and clinical exposure since one of the main features of the nursing profession is integrating theory into practice, which makes clinical training and experience a very important component of Nursing Education. Clinical experiences prepare and stimulate students' critical thinking and problem-solving skills (Apolinaro and Moagi, 2023:3). Motsaanaka, Makhene and Ally (2020:4) point out that participants expressed their anger and frustration when professional nurses used them to push workload in the wards, and as a result, further resulting in missed learning opportunities. Furthermore, some students felt that they were not treated as students and were just used as extra pairs of hands by their seniors in the workplace.

According to Apolinaro and Moagi (2023:4), there were learning opportunities for students in clinical facilities, but the absence of clinical preceptors to facilitate clinical teaching in COVID-19 wards deprived them of learning clinical skills that would have equipped them to care for patients with COVID-19. They could have been allowed to work in the COVID-19 wards so that they could gain more experience. On the contrary, Ulenaers *et al.* (2021:4), found that some students felt comfortable when the nursing school made the decision not to let them care for COVID-19 patients. Furthermore,

students' level of fear became worse when they found themselves caring for COVID-19 patients. Motsaanaka, Makhene and Ally (2020: 4), state that participants further reported that wards had fewer staff members and professional nurses were overworked, and as a result, this led to students not being adequately exposed to clinical learning and opportunities to practice nursing skills. Furthermore, professional nurses had negative emotions of stress and poor staff morale because of being overworked. This situation caused a lack of interest in teaching student nurses, and this led to further limiting students' clinical learning opportunities.

In addition to this, Apolinaro and Moagi (2023:4) argue that student nurses had to deal with the emotional impact that came with their experiences and, they wished for preceptors to support them emotionally, as everyone was undergoing a stressful season. They would also have appreciated more clinical guidance and support from their clinical facilitators. Motsaanaka, Makhene and Ally (2020:3) describe negative emotions as personality variables that include stress, anxiety, depression, frustration, and contempt. Furthermore, participants expressed negative emotions of anger, frustration, and lack of motivation that were due to a lack of clinical learning opportunities.

2.4.5 Fear of Not Completing the Training Course

According to Jarvis *et al*. (2021:1), student nurses were provided with the option not to return to clinical practice during the pandemic, however, almost all students chose to go to clinical areas because they wanted to complete their qualification. The main goal for all the students was to complete their training course. Apolinaro and Moagi (2023:5) point out that student nurses were limited to only a few 'safe' units for clinical practice. Not being able to practice in certain departments in the clinical areas caused them to have fewer clinical skills and knowledge related to those restricted departments. Such restrictions in clinical facilities meant that student nurses were not able to perform all the required practical procedures in practice and, this meant that they had to execute those procedures in simulation laboratories under the guidance and supervision of their clinical facilitators. Furthermore, this adversely impacted their learning as they could not meet the requirements of clinical hours and their clinical practice objectives (Apolinaro and Moagi 2023:8). On the one hand, Zulu, Du Plessis,

and Koen (2021:8) state that the goal of the student nurses was to acquire skills, knowledge, and experience in the nursing profession, and this helped them to continue despite the challenges. On the other hand, Jarvis *et al.* (2021:5) argue that the participants had mixed feelings about completing their degrees when they were faced with the COVID-19 pandemic.

2.4.6 Coping Skills During the COVID-19 Pandemic

According to Zulu, Du Plessis and Koen (2021: 7) most of the participants had a belief that they keep bouncing back from their challenges at the clinics because of their love, passion, and pride for the nursing profession. This is what made them cope in the clinical areas. Furthermore, the participants mentioned that their strengths as well as the support they received from other people enabled them to be resilient. In addition, Zulu, Du Plessis and Koen (2021:8) assert that according to the participants, support from staff members, their family members, and peers assisted them to cope with the pandemic, irrespective of the challenges they experienced. Furthermore, having faith in God and confidence helped them to cope and participants also expressed that having negative experiences and challenges strengthened them emotionally as well as spiritually.

Adding to these coping skills, Jarvis *et al*. (2021:7) mention that participants also expressed that the information they received to deal with the pandemic lessened their anxiety. Furthermore, they also reported positive adaptive coping strategies in their daily lives which helped them to protect themselves and their families, and that was a demonstration of a sense of self-agency.

2.4.7 New Approaches to Teaching and Learning

The pandemic called for innovative ways to continue teaching and learning. Powell, Scrooby and van Graan (2020:215) recommend that high-fidelity simulation be part of the curriculum of the nursing programmes and that nurse educators and students should be trained on how to use it as a clinical teaching-learning method. Furthermore, this high-fidelity simulation would enhance clinical skills development through theory-practice integration, and as a result, lead to better patient safety. Similarly, Makhado *et al*. (2022: 9) also recommend the introduction of a new learning modality that should

be accompanied by a thorough orientation of both student nurses and lecturers to facilitate effective learning. Furthermore, there should be a mechanism for addressing the developing problems related to online teaching and learning on time so that these problems are resolved timeously as the people who are involved in the programme are geographically dispersed. If there are any problems experienced, they should also be communicated to all parties involved.

2.5 Theoretical Framework

Schlossberg 's Transition Theory, which was developed by Nancy Schlossberg in 1981, guided the study. According to this theory, humans are in transition in their lives. This theory has three constructs namely, approaching transitions, potential coping resources, and "taking charge", which means strengthening resources.

2.5.1 Approaching Transitions

Schlossberg, in her theory, describes how people approach transition. This component involves the identification of individual's perspectives where they are within the transition regarding whether they are "moving in", "moving through" or "moving out" (Anderson, Schlossberg and Goodman 2012:59). Furthermore, when moving into a new situation, people must be acquainted with new roles, relationships, and routines. For example, students needed to understand what their roles and responsibilities were in the clinical area and clinical educators had to prepare themselves as well as student nurses to approach each transition during different waves of COVID-19, so that they were able to move through and out of it successfully. This involved adhering to strict protocols and COVID-19 routines as dictated by those in charge of the clinical area. These theorists add that once people "know the ropes" they experience "the moving through" period. This means that people can progress to the next stage, which is "the moving through" stage.

During "the moving through stage", people try to adjust, balance and integrate the demands of the new situation with the rest of their daily lives (Anderson, Schlossberg and Goodman 2012:59). For example, during the COVID-19 pandemic, students, clinical educators and those in clinical settings had to practice social distancing, hand

sanitizing, wearing face masks and donning the protective equipment in the clinical area to prevent the spread of infection.

The next and last step of this transition is "the moving out stage". During this stage, people who are involved in a transition are looking forward to the next thing, and there is a period of stability (Anderson, Schlossberg and Goodman Anderson 2012: 59). At this stage, people have become used to the pandemic and are no longer afraid because they have learned new ways of coping with the effects of the pandemic. This could also wishfully be the time when the pandemic would be over, and life goes back to normal. The COVID-19 pandemic was a transition from the known to the unknown for both student nurses and educators. No pandemic or similar crisis of the magnitude of COVID-19 had occurred in the country.

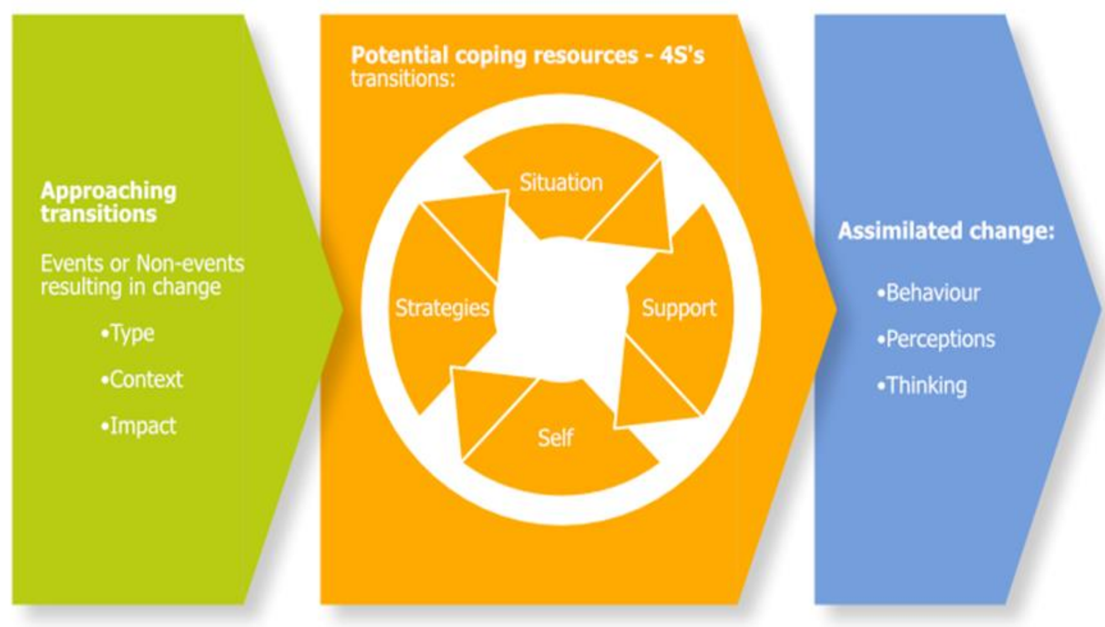

Figure 1: Schlossberg Transition Theory (Anderson, Goodman and Schlossberg, 2012).

2.5.2 Potential Coping Resources

Under this construct, Schlossberg identifies four major sets of factors that are key in influencing a person's ability to cope with a transition. These are known as the 4S's namely, situation, self, support, and strategies.

2.5.2.1 Situation

An individual assesses the situation and considers the following factors: **Trigger**: What caused the transition? Is the transition anticipated or not? Where is an individual in this situation, at the beginning, in the middle, or at the end of the transition? How does the transition relate to one's timing from a social perspective? **Control**: What aspects of the transition can an individual control if there are any? **Role change**: Does the transition involve any role change? **Duration**: Is the transition seen as something permanent or temporary? **Concurrent stress**: What and how serious are the stresses facing the individual now, if any? **Assessment**: How does the individual view the situation, in a positive or a negative light? (Anderson, Schlossberg and Goodman 2012: 67-68). According to this theory, during the COVID-19 pandemic, clinical educators and students needed to understand where they were. Were they in the beginning, in the middle, or at the end of the transition for them to be able to navigate their way through the situation? Furthermore, for them to cope with the transition, it would depend on how the students viewed their transition; if positive, that individual would be in control of the situation but if negative, they might feel worthless (Schlossberg 2008:62).

2.5.2.2 Self

According to Anderson, Schlossberg and Goodman (2012:73), self relates to personal and demographic characteristics such as socio-economic status, age, state of health, culture, gender, and ethnicity. Furthermore, self refers to psychological resources such as one's ego (maturity), one's outlook on life, and one's level of resilience to the transition. All of these factors directly dictate how each person will respond to the transition. According to Schlossberg (2008:62), a person's outlook on life may be positive or negative. Furthermore, those who are negative or have low self-esteem do not succeed in a transition. This could mean that clinical educators and student nurses with a negative attitude during this transition might be overwhelmed. The interviews

assisted the researcher to find out more about the participants' self-characteristics and thus their experiences during the pandemic.

2.5.2.3 Support

Support is often viewed as key to handling a stressful situation. Schlossberg (2008: 75) states that men and women should be supported differently because they experience stress differently. Furthermore, a strong support system during the transition can help individuals both physically and mentally. Age is also a factor in the support system and can change over time. During interviews, it was interesting to find out who the participants looked up to for support, whether they were supported by their peers, educators, families, and members of the community. Schlossberg (2008:75-76) points out that clinical educators and students need to get affection, affirmation, and aid as their support.

2.5.2.4 Strategies

Schlossberg argues that there are three main coping responses for an individual in a transition: "responses that modify the situation", "responses that control the meaning of the problem at hand," and "responses that help the individual manage stress after it has already occurred" (Anderson, Schlossberg and Goodman 2012: 89). On the one hand, Schlossberg (2008:79) describes strategies as coping resources that individuals bring to a transition. Furthermore, individuals may either ask for assistance to cope with the situation or may try to cope on their own independently. It was interesting for the researcher to find out what were the participants' coping strategies during the pandemic, in the clinical placement setting.

2.5.3 Strengthening Resources

Schlossberg (2008:62) integrates several counselling techniques with a focus on developing the transitioning individual's coping resources. Applying the 4S's System to the synthesis of relevant literature, enables the clinical educators and students to transition through the situation. Furthermore, the individual experiencing the transition has to have coping mechanisms so that they make the best out of what is available. This means that Nursing Education had to be available to support students and their

clinical educators by strengthening the resources that they already had at their disposal. Finally, Schlossberg's transition theory created a good framework for this literature study. Nursing Education Institutions needed to use the 4S's of Schlossberg's model while they were navigating their way through the transition. The strong 'self' of a student nurse or educator enhances the application of strategies to overcome challenges. Positive personal attributes such as optimism and resilience were very necessary in this transition (Anderson, Schlossberg and Goodman 2012:62). Support and supervision of students by the nursing staff and accompaniment by their clinical educators in the clinical area was very critical.

2.5.4 Application of the Theoretical Framework

The researcher used purposive sampling for the study participants, guided by the principles of Schlossberg's Theoretical Framework when selecting participants, taking into cognizance the self-factor of the 4S's. According to Anderson, Schlossberg and Goodman (2012:73), self refers to personal and demographic characteristics such as socio-economic status, age, state of health, culture, gender, and ethnicity. All these factors directly dictate how each person will respond to the transition.

The researcher further applied this theoretical framework when formulating interview questions. For example, the researcher was interested in seeing how the self-factor helped the nurses cope with the pandemic in the workplace. It is also interesting to know what kind of support, if any, did the nurses receive from the organisation or management and how it influenced their clinical practice. What strategies did they employ to cope with the COVID-19 pandemic? It was interesting also to know what resources were available at their disposal to strengthen them. Was there a professional psychosocial service available for the staff for example debriefing sessions or they merely relied on their resilience. Drawing from their experiences, what reformative programmes and psychosocial programmes did they think helped improve nurses' working conditions in a transition such as the COVID-19 pandemic? The theoretical framework was also applied to guide the reporting and discussion of this study's findings.

2.6 Chapter Summary

This chapter presented the lived experiences of nurses during the COVID-19 pandemic in different parts of the world, but with a specific focus on the experiences of student nurses and clinical educators in selected campuses of the Gauteng College of Nursing, in South Africa. The following chapter presents this study’s research methodology.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

The purpose of this chapter is to describe the research methodology that was utilized to explore student nurses' and educators' experiences of clinical teaching and learning during the COVID-19 pandemic in selected campuses of the Gauteng College of Nursing. The research approach that was utilized in this study is qualitative research. According to Polit and Beck (2018:272), the goal of qualitative research is to develop a rich understanding of the phenomenon that exists and is constructed by individuals within their context. In this chapter, the study setting, the data collection methods as well as the data collection process are also discussed.

3.2 Research Design

Creswell and Creswell (2018:49) define research design as the plan for conducting the research study. In other words, how the research would be conducted from the beginning until the researcher obtains the research findings. An exploratory-descriptive qualitative cross-sectional research design was utilized in this study. According to Polit and Beck (2018: 281), descriptive qualitative studies tend to be eclectic in their designs and methods and are based on the general premises of constructivist inquiry. This research design was used to collect data to explore student nurses' and educators' experiences of clinical teaching and learning during the COVID-19 pandemic at the Gauteng College of Nursing.

3.2.1 Qualitative Research

Creswell and Creswell (2018:43) describe qualitative research as an approach to exploring and understanding the meaning individuals or groups ascribe to a social or human problem. The process of research involves emerging questions and procedures, data typically collected in the participants' settings, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data. Furthermore, the final written report of the research study has a flexible structure. The scholars who engage in this type of inquiry support a specific way of looking at research that honours an inductive style, a focus on individual meaning, and the importance of reporting the complexity of a situation.

Furthermore, Creswell and Poth (2018:84) point out that qualitative research is a systematic approach that is used to describe experiences and situations from the perspectives of persons in that situation. In addition, they state that they conduct qualitative research because they need a complex, detailed understanding of the issue. This detail can only be established by talking directly with people, going to their homes or places of work, and allowing them to tell their stories unencumbered by what they expect to find or what they have read in the literature.

To support this view of allowing participants to tell their stories, Polit and Beck (2021: 486) maintain that qualitative research is also known as naturalistic inquiry, meaning that the research is conducted in natural settings. Therefore, a qualitative approach was more suitable in this study because it involved the researcher interacting and communicating with the participants closely in the areas where they worked and lived. Participants were able to give an account of their experiences.

3.2.2 Exploratory-Descriptive Research

Grove and Gray (2019:36) state that explorative-descriptive qualitative research is conducted to address an issue or a problem in need of a solution. Furthermore, qualitative researchers use this methodology when they want to explore a problem area using various qualitative techniques, to describe the topic of interest and promote understanding. These authors further assert that exploratory-descriptive qualitative studies are developed to provide insight as well as information into clinical or practice problems. On the one hand, Polit and Beck (2018:287) argue that descriptive qualitative studies are not embedded in a disciplinary tradition and such studies may be referred to as qualitative studies, naturalistic inquiries, or qualitative content analyses. On the other hand, the purpose of descriptive research is to observe, describe, and document a situation as it naturally occurs (Polit and Beck 2021:196). In this study, exploratory-descriptive research helped to answer questions such as ‘what were the student nurses’ and educators’ experiences of clinical placement during the COVID-19 pandemic.

3.3 Research Paradigm

A paradigm is a world view, a way of looking at natural phenomena that encompass a set of philosophical assumptions that guide one's approach to the inquiry under study (Polit and Beck 2021:13). Creswell and Creswell (2018:42) further define a research paradigm as a research approach which involves plans and procedures for research that span the steps from broad assumptions, detailing methods of data collection, analysis, and interpretation. This study used the naturalistic paradigm, sometimes known as the constructivist paradigm. This paradigm is aligned with qualitative research methods and is based on the fact that reality is not fixed but exists within a particular context. Furthermore, the participants who are involved in a particular research study are the ones who construct this reality. Polit and Beck (2020:16) further point out that it is crucial to listen to the voices of the participants to understand a phenomenon. From the researcher's point of view, it was very important to ensure that participants expressed their views regarding what they experienced in clinical placement during the COVID-19 pandemic. Furthermore, it was crucial that the researcher listened to the voices of the participants and captured everything they said through recordings, to understand their situation.

3.4 Research Setting

The study was conducted at the Gauteng College of Nursing, which has six campuses in total. Two of the six campuses; Ann Latsky Campus and Chris Hani Baragwanath Campuses offer R425, which is a four-year Nursing Diploma leading to a qualification as a general nurse, community health nurse, psychiatric nurse, and midwife. Both campuses are situated in Johannesburg; Ann Latsky Campus is adjacent to Helen Joseph Hospital and the University of Johannesburg main campus. Chris Hani Baragwanath Campus is located within Chris Hani Baragwanath Hospital, the largest hospital in Africa and the third largest hospital in the world, situated in Diepkloof township, in the South of Johannesburg. The city of Johannesburg is in the province of Gauteng, which is one of the nine provinces of South Africa. The name Gauteng in Sesotho and Setswana languages means 'place of gold'. This province is situated on the Highveld and is the smallest province by land in South Africa. Though it accounts for only 1.5% of the country's land area, it is densely populated, as it is home to more than a quarter of its Gauteng population.

3.5 Study Population

Polit and Beck (2020: 306) define the study population as the entire collection of cases in which a researcher has an interest. The study had two different types of population namely, student nurses and their clinical educators.

3.5.1 Student Nurses

The study population included all student nurses from the selected campuses and the target population was student nurses in the R425 programme, who were in clinical placement during the COVID-19 pandemic. There were 128 student nurses from one campus and 46 from the other campus. In total, the students were 174. Although this programme is being phased out, these student nurses had peculiar experiences and lessons learned will assist future student nurses.

3.5.2 Nurse Educators

The population of nurse educators were all educators who taught in the selected campuses and the target population were educators who were responsible for placement and accompaniment of student nurses at clinical sites during the COVID-19 pandemic. There was a total of 15 educators who were involved in clinical teaching during the pandemic. Those educators had first-hand experiences of clinical teaching during the pandemic.

3.6 Recruitment of Participants

Creswell and Creswell (2018:165) state that it is important to obtain the necessary permissions before a study is undertaken. The researchers need to obtain approval from individuals in authority or gatekeepers, to gain access to sites and to study participants. Furthermore, this often involves writing a letter that specifies the extent of time, the potential impact, and the outcomes of the research to be conducted. In line with this statement, permission to conduct research at the selected campuses was sought from the Provincial Protocol Review Committee (PPRC) (Appendix F2), the Gauteng College of Nursing Research Committee through the Director of Gauteng College of Nursing (GCON), once the Ethics Research Committee of the Durban University of Technology had granted a provisional approval (Appendix F1).

Permission for student nurses and educators to take part in the study was sought from the heads of the two campuses and the Research Committee coordinators of the two campuses.

An advertisement poster (Appendix D) was placed on the notice boards of the two campuses and the students' residences. Arrangements were made to meet with the students in class during their last period. The student nurses and educators were met in different rooms, but the recruitment strategy was the same for both. In the meeting, the aim and objectives of the study were explained to the participants by the researcher and how they were expected to participate, wherein any misunderstanding was clarified. The researcher handed the information letters to student nurses and nurse educators (Appendix A). After all participants had been made to understand the research project and their roles in the study, they were asked to sign an informed written consent (Appendix B) before the interviews began.

Participants were assured of confidentiality during data collection and reporting. Pseudonyms were used for participants instead of their actual names to promote and maintain confidentiality. The participants were told that participation was voluntary; whenever they wanted to withdraw, they could do so without any consequences.

3.7 Sample and Sampling Strategy

A sample is defined as a subset of the population (Polit and Beck 2020:307). The sampling strategy in this study was non-probability purposive sampling. Polit and Beck (2020:312) confirm that the researcher's knowledge is key in selecting the participants, this sampling strategy is aligned with qualitative research. The significance of purposive sampling is that participants could provide rich data to answer the question of interest to the researcher. The researcher selected the sample based on her subjective judgement rather than random selection. Student nurses who were in clinical placement during the COVID-19 pandemic and educators who were responsible for accompaniment were sampled.

3.7.1 Sampling of Campuses

There is a total of six campuses in the Gauteng Colleges of Nursing, however; only two campuses were purposively sampled because they are larger and are located within the city of Johannesburg, which was severely affected and thus had the highest number of COVID-19 positive cases in the whole province of Gauteng. These campuses were also the only ones that had students who were in placement during the COVID-19 pandemic. Other campuses are smaller and on the outskirts of Johannesburg and were not as severely affected by COVID-19 infections. The two sampled campuses had a total of 171 student nurses registered for the R425 training programme.

3.7.2 Sampling of Student Nurses and Nurse Educators

The researcher conveniently sampled participants from student nurses who were in the R425 nursing programme, as these were students who were in clinical placement during the pandemic. Student nurses who were interested in participating after reading the poster, contacted the researcher to indicate their interest, using the cell phone number that was on the poster. Nurse educators who were responsible for clinical placements and accompaniment of those students were also sampled from the two campuses. The student participants were met at their nurses' residences and their places of work, where they had indicated their availability. Only those who met the inclusion criteria and agreed to participate were sampled for the study.

3.8 Sample Size

Creswell and Poth (2018: 224) state that the question of sample size is an important decision in the sampling strategy in the data collection process. Furthermore, one general guideline for sample size in qualitative research studies is not only to study a few sites or individuals but it is important also to collect a lot of detail about each site or individual studied, because the intention in qualitative research is not merely the generalization of the information. In this study, the sample size was determined by data saturation. According to Creswell and Creswell (2018: 298), the researcher stops collecting data when all the themes have reached saturation, meaning that no new information is coming forth from the participants. Similarly, Polit and Beck (2018: 306)

assert that in qualitative research, data saturation is a guiding principle that involves sampling to the point at which no new information is obtained and redundancy is achieved.

3.8.1 Sample Size of Student Nurses

The researcher reached data saturation at the first campus before moving to the next one. The minimum sample size in qualitative studies is typically between 10 to 15 participants (Polit and Beck 2021: 504). In this study, a maximum total of 15 student nurse participants was interviewed. However, data saturation still guided the sample size. Additional participants or new data sources did not provide any new information which confirmed that sampling had reached saturation. According to Creswell and Creswell (2018: 298), saturation is when gathering fresh data, no longer sparks any new insights or reveals new properties. This is when one has an adequate sample for the research study.

3.8.2 Sample Size of Nurse Educators

The sample size for nurse educators was four however, data were collected until saturation was reached in one campus before the researcher moved to the next campus.

3.8.3 Inclusion Criteria

This is the criteria by which population characteristics are specified (Polit and Beck 2021: 261).

- Campuses located in Johannesburg because they were larger, severely affected by the COVID-19 pandemic, and offered the R425 nurse-training programme.
- Student nurses registered for the R425 training programme in the selected Gauteng campuses because they were in clinical learning during the pandemic and were 18 years old and above.
- Nurse educators who were responsible for clinical placement and accompaniment of R425 student nurses during the pandemic.

3.8.4 Exclusion Criteria

This is the criteria that the sample for the study must not possess (Polit and Beck 2021: 261).

- Smaller campuses of the Gauteng College of Nursing, because they did not offer R425 training programmes and their R171 student nurses were not in clinical placement during the pandemic.
- Student nurses from excluded campuses because they were not in clinical placement during the pandemic.
- Nurse educators who taught in the R171 programme, because their students were not in clinical placement during the pandemic.

3.9 Data Collection

The researcher used semi-structured individual face-to-face interviews to collect data from participants. Interview is a data collection method in which the researcher asks questions from participants usually face-to-face but can be done telephonically as well (Polit and Beck 2021:23). The semi-structured interview technique was chosen for this study because data that were collected, were based on the participants' views regarding their experiences of clinical teaching and learning during the COVID-19 pandemic. Creswell and Creswell (2018:263) state that one of the methods of data collection in qualitative research is interviews, where a researcher conducts face-to-face interviews with participants. These authors recommend that a researcher takes notes during a taped interview as a backup so that should the equipment fail, there is still data collected. According to Polit and Beck (2021:288), interviews are considered to be a good strategy for collecting data because of the high response rate in face-to-face interviews. Furthermore, in-depth interviews are the most widely used method of collecting data for qualitative studies (Polit and Beck 2018: 306).

3.10 Data Collection Tool

According to Polit and Beck (2018:297), interviewers use a written topic guide or interview guide to ensure that all question areas are attended to. Furthermore, the interviewer's responsibility is to encourage participants to talk freely about all the topics in the interview guide.

Two interview guides were utilized during data collection; one for student participants and the other for educator participants. Each interview guide had the date of the interview, the time, the campus name, and the participant's pseudonym. The interview guides had section A, which comprised demographic data of the participants such as age, gender, and marital status. Section B contained the main guiding open-ended question to elicit the experiences of teaching and learning during the COVID-19 pandemic. This was followed by eight questions and the researcher had to probe in between, whenever necessary to obtain more information. For example, "What happened next?" "tell me more about……". Questions were formulated in English, which is the medium of instruction at the nursing college (Appendices C1 and C2).

3.10.1 Pilot Study

A pilot study was conducted in one of the campuses, but the students and educators who participated in the pilot study did not become part of the main study. The sampling and ethical considerations were followed for the main study. The interviews were guided by the responses of the participants and the researcher had to probe to extract more information from each participant.

3.10.2 Data Collection Process

Data collection commenced from 1st July 2023 to 29th August 2023 after approvals and permission from gatekeepers were obtained as follows; Provisional approval from the Durban University of Technology, was obtained on 17th February 2023 (Appendix F1), Provincial Protocol Review Committee on the 14th of March 2023 Appendix F2), the campus heads and the principal of GCON on the 24th of March 2023 (Appendices F3 and F4). The full approval was obtained from Durban University of Technology on the 6th of June 2023 (Appendix F5). Signed consent forms were collected and placed in a separate envelope so that they were not traced back and linked to the interviewees.

Interviews took place at the students' residences and the clinical areas as well as virtually for some students and educators. Some educators were interviewed in the comfort of their offices. The venue where participants were interviewed was very quiet, free from noise and had two chairs; one for the researcher and the other one for the participant (interviewee). Any kind of distraction was prevented, and the venue was well lit and well ventilated. Before any interview could commence, participants' anxiety

was allayed; they were told that they could stop participating at any stage because their participation was voluntary, and their confidentiality was reiterated. Each interview lasted between 30 to 45 minutes, per participant depending on how much they talked. The researcher used an audiotape recorder to record the interviews with permission from participants as recommended by Polit and Beck (2020:343), who assert that most researchers prefer to tape record the interviews, to be transcribed at a later stage.

3.10.2.1 Student Nurses' Interviews

Semi-structured individual interviews were conducted while students were at their residences in the evenings between 16h00 and 19h00 during weekdays. This time was chosen by the researcher to avoid disrupting participants from their school or clinical hours. Participants were interviewed in a quiet well-lit room with no disruptions, the door was closed however, windows were left opened for good ventilation and phones were switched off. The researcher created rapport with the participants to put them at ease so that they could speak freely. If participants became anxious due to emotions being evoked from relating their experiences, the researcher is a professional nurse who is trained in basic counselling skills and would reassure the participants that there was available assistance should the need arise. Arrangements were made with the professional counselling department, which is available at the respective campuses, if that was required. At the end of the interview, the researcher thanked the participants and requested their permission to be contacted again for further information, if the need arose.

3.10.2.2 Nurse Educators

The researcher asked each educator who agreed to participate in the study for a suitable time and venue for the interviews. They were advised that the venue should be quiet and well-lit with no disruptions such as noise and people coming in and out to offer privacy and confidentiality. The researcher greeted the participants and reiterated ethical issues discussed during recruitment, to put the participants at ease so the interviews would commence. At the end of each interview, participants were thanked for their participation.

3.11 Data Analysis

In qualitative research, data analysis occurs concurrently with data collection. Therefore, data analysis was done at the end of each day of the interviews to search for important concepts and patterns. Furthermore, the purpose of data analysis is to organize, provide structure to and elicit meaning from data (Polit and Beck 2021: 534). Thematic analysis was used to analyse data. Polit and Beck (2020: 481) assert that in qualitative studies, audiotaped interviews and field notes are the major sources of data. They further maintain that verbatim transcription of the audio tapes is a very critical step in preparing for data analysis. It is also critical that researchers ensure that transcriptions are accurate and reflect what transpired during the interview (Polit and Beck 2020: 481). Furthermore, they point out that the researcher needs to read the data repeatedly, searching for deeper understanding and meaning. Tomazeski, Zarentsky and Gonzalez (2020:4) state that when conducting data analysis, researchers need to do the coding, and sorting as well as the identification of themes and relationships from the data. Additionally, Creswell and Creswell (2018:306) maintain that qualitative data analysis follows a sequence of steps, which range from specific to general, as described below, which was done in this study.

Step 1: Organization and preparation of the data for analysis

In this step, the researcher transcribed interviews verbatim from the voice recorder and, at the end of each interview day, sorted and arranged data into different types depending on the data source.

Step 2: Reading or looking at all the data

The researcher read and listened to the audio tape several times to get immersed in the data. In this step, the researcher had an opportunity to reflect on the overall meaning of the data gathered. The researcher looked at what participants were saying, generally, reading their ideas. What was the overall impression of the information the researcher was looking at and how credible it was?

Step 3: Coding all of the data

During this step, the researcher coded the data, and this process involved taking segments of sentences and arranging them according to codes. It was at this stage

that the researcher would then use codes from the data to identify similar ideas or views and classify them under one code.

Step 4: Generating a description and themes

The researcher narrated the findings of the analysed data. This was a discussion that mentioned a chronology of events, and a detailed discussion of several themes and sub-themes. The researcher described the themes emerging from the analysed data according to her understanding. At this stage, the researcher grouped the collected information into different themes and several sub-themes, which had emerged from the main themes, according to how she understood the collected data.

Step 5: Representing the description and themes

This step is about the description and themes presented in the qualitative study and it is common to use a narrative to show the findings of the analysis. The researcher mentioned a chronological sequence of events and discussed several themes and subthemes in detail. In a nutshell, the researcher had to describe the themes as they emerged in her study and narrate the findings of her analysis of the data at hand.

Step 6: The interpretation of the data

This step comes at the end where the researcher interpreted the findings using themes that had been identified, categorized them, and wrote the summary of findings. At this stage, the literature review came in handy, the researcher compared findings with the available literature. According to Creswell and Creswell (2018:312), it could also be a meaning derived from a comparison of the findings with information obtained from the literature or theories. Furthermore, these authors suggest that the findings confirm past information or diverge from it. Ultimately, the researcher put together the interconnection of all the categories into a meaningful sequence of events leading to a story or narrative.

3.12 Data Management and Storage

Confidentiality was vital in keeping records of electronic and paper-based research documents. Collected data were stored in a manner that ensured that participants' confidentiality was maintained throughout the research process and the dissertation

writing and publication process. Participants' details were not recorded nor documented; names of participants were not called out in the audio recording. At the onset of the interview, pseudonyms were assigned to the participants.

Collected data were kept in a safe and secure area for the duration of the research. All hard copy records such as informed consent, interview sheets, and transcripts were stored in a locked cupboard, the key for which was kept by the researcher. Electronic data such as audio records were transferred to an external hard drive which was secured with a pin code known to the researcher only and thereafter was deleted from the voice recorder. In line with this data management procedure, Creswell and Poth (2018:254) maintain that at an early stage in the data analysis process, researchers typically organize their data into digital files and create a file naming system. This consistent application of a file naming system ensures materials can be easily located in large databases of text (recordings) for analysis either by hand or by a computer. All research records are kept for five years and will, thereafter, be deleted and shredded by the researcher.

3.13 Trustworthiness

Trustworthiness is a concept used by qualitative researchers to describe the reliability and validity of their studies. When researchers use this concept, they are looking at issues such as credibility, confirmability, consistency, and applicability of their studies. The dimensions of trustworthiness are discussed below.

3.13.1 Credibility

According to Polit and Beck (2020: 492), credibility refers to confidence in the truth of the data and its interpretation. The findings of the study have to be believable and dependable as well. The researcher ensured that the participants were not coerced into participating in the study but were genuinely interested. The researcher, therefore, questioned the participants more than once on the same matter to get to the truth. Participants' responses were audio recorded to keep the true record of the data collected.

3.13.2 Confirmability

Polit and Beck (2020:511) state that confirmability refers to the objectivity of the data. This means that the findings are free from the researcher's bias. Confirmability can prove to a very large degree that the findings reflect the experiences of the participants, and it is free of the researcher's preferences. The researcher achieved this by making sure she obtained the views and opinions of the participants by probing for more information where she was not sure, to confirm what the participant was saying without making her conclusions. The researcher described all steps of the research process up to the reporting of findings. The safekeeping of research records as evidence of the project was ensured by the researcher.

3.13.3 Dependability

Polit and Beck (2020:492) maintain that credibility cannot be attained in the case where there is no dependability, just as in quantitative research validity cannot be achieved in the absence of reliability. The dependability question that could be asked is whether the study findings would be the same if the study were replicated with the same or similar participants in a similar context. The researcher ensured that the research design, data collection and data analysis were done correctly, to ensure dependability.

3.13.4 Transferability

Transferability is concerned with the extent to which the findings of a qualitative study can be transferred to the next or other settings (Polit and Beck 2020:492-493). Transferability is used interchangeably with generalizability, meaning that the findings of the study apply to other groups or settings.

3.14 Ethical Considerations

Respect for human beings is the basis for ethical considerations in research including beneficence and justice to ensure respect for participants to protect them from harm and ensure fairness in the course of the research study, according to the Belmont Report of 1979 (National Institutes of Health, 1979).

3.14.1 Ethical Standards

This study was conducted following the Durban University of Technology's ethical standards. An ethical clearance was obtained from DUT's Institutional Research Committee, to conduct the research study. The researcher obtained a certificate from the online ethics training provided by TRREE (Appendix E).

3.14.2 Permissions

Permission was requested and obtained from the gatekeepers (Appendices F1, F2, F3, F4 and F5). The management of the two campuses was reassured that the researcher would not disturb the participants during their learning and teaching exercises. To ensure this, the researcher made an arrangement to interview the participants during the times when they were comfortable and free from their learning and teaching responsibilities.

3.14.3 Informed Consent

According to Polit and Beck (2018:139), informed consent means that participants have adequate information about the study, comprehend the information, and have the power of free choice, enabling them to consent to or decline participation voluntarily. Furthermore, an important procedure for safeguarding participants involves obtaining their informed consent. Therefore, an information letter (Appendix B) was made available to the participants which explained the research project. The letter briefly explained the aim of the study to be undertaken and how they were expected to participate. The participants signed the informed consent (Appendix B2) after they had understood their roles and had agreed to participate in the study.

3.14.4 Voluntary Participation

Participants were informed that their participation was voluntary, and they were free to withdraw at any stage of the research without any consequences. Participants were informed of what was expected regarding participation, such as how much time would be required, the voluntary nature of participation, and the potential costs and benefits of the project.

3.14.5 Confidentiality and Anonymity

Creswell and Creswell (2018:169) explain that the anonymity of individuals, roles, and incidents in the project should be protected. In research, investigators disassociate names from responses during the coding and recording process. Furthermore, in qualitative research, inquirers use aliases or pseudonyms for individuals to protect the identities of the participants. To protect the participants' confidentiality, pseudonyms were used. The participants were also assured of confidentiality and anonymity throughout the study. Notes and transcripts did not contain information about the participants' real names. Collected data were only accessible to the researcher and supervisors to protect respondents' right to confidentiality. Electronic data were password protected, and hard copies were locked in a safe cabinet, which was accessible only to the researcher and supervisors. After the completion of the study, the collected data are still kept for five years and thereafter will be deleted from the computer, and hard copies will be destroyed by the researcher.

3.15 Chapter Summary

This chapter presented a detailed account of the study's research methodology that was utilized. A descriptive qualitative study method was used to analyze and represent the student nurses' and educators' experiences of clinical teaching and learning during the COVID-19 pandemic in selected campuses of the Gauteng College of Nursing. The sample consisted of 15 purposefully selected participants who met the predetermined criteria, according to the study objectives. Semi-structured interviews using an interview schedule were used to collect data. Content analysis was used to analyze the verbatim transcriptions. The researcher followed a sequence of steps which ranged from specific to general in analyzing the data (Creswell and Creswell 2018:306). The data were coded and grouped into sub-categories and categories that led to the identification of three themes. To protect the rights of the participants, ethical principles were adhered to. Trustworthiness was assessed to ensure the reliability and validity of the qualitative findings.

CHAPTER 4: PRESENTATION OF FINDINGS

4.1 Introduction

The previous chapter discussed the methodology used in this study. The current chapter presents the findings of the study from analyzed data, where participants were asked about their experiences of clinical learning and placement during the COVID-19 pandemic.

4.2 Sample Realization

Nineteen participants; 15 student nurses and four clinical educators who were selected purposively from the Gauteng College of Nursing were interviewed as only those who were in clinical placement during the COVID-19 pandemic could provide in-depth information about what their experiences were.

4.3 Demographic Characteristics of Participants

15 participants were student nurses; nine females and six males whose ages ranged between 30 and 52 years. The educators were four females whose ages ranged between 53 and 64 years. All four nurse educators were clinical facilitators (Table 4.1).

Table 4.1 Demographic characteristics of participants

Participant number	Category	Gender	Age in years
Participant 1	Student nurse	Male	30
Participant 2	Student nurse	Female	30
Participant 3	Student nurse	Female	36
Participant 4	Student nurse	Female	32
Participant 5	Student nurse	Female	35
Participant 6	Student nurse	Male	32
Participant 7	Student nurse	Female	44

Participant 8	Student nurse	Female	48
Participant 9	Student nurse	Male	30
Participant 10	Student nurse	Female	52
Participant 11	Student nurse	Male	31
Participant 12	Student nurse	Female	30
Participant 13	Student nurse	Female	31
Participant 14	Student nurse	Male	30
Participant 15	Student nurse	Male	32
Participant 16	Nurse educator	Female	53
Participant 17	Nurse educator	Female	54
Participant 18	Nurse educator	Female	58
Participant 19	Nurse educator	Female	64

4.4 Presentation of Findings

The codes, sub-categories, categories, themes, and sub-themes that emerged from the data are presented in Table 4.2. Three themes and 16 sub-themes emerged from the analyzed data. Participants' verbatim iterations were used to support the findings and to indicate how themes and subthemes were developed. These verbatim quotes are presented in italics.

Table 4.2: Meaning units, codes, sub-categories and themes extracted from content analysis of the qualitative data

Theme 1: Clinical experiences and clinical learning during COVID-19 pandemic			
Meaning unit	**Codes**	**Sub-categories**	**Categories**
During the hard lockdown, nobody could go to	COVID-19 infections were still high.	No clinical teaching could take place.	Clinical learning areas are not

clinical areas for three months. (Student SW).			accessible during lockdown.
Having incomplete SANC requirements threatened our progression to the next level of training. (Student PK).	Fear of missing clinical hours.	Fear of the training course being extended.	Clinical hours.
There was no provision of PPE for students but for the permanent staff. (Student NM).	Discrimination of students in the clinical areas.	No Provision of PPE for students.	Challenges with personal protective equipment
Some students were told to wash and repeat the same PPE. (student NM).	Students felt unprotected from the COVID-19 virus.	Not enough PPE for students.	
Some of the PPE caused discomfort and fatigue for the users (Student SS).	Some could not perform their duties properly.	The PPE was uncomfortable.	
Some experienced allergic reactions from wearing the PPE. (Student PK).	Some had to take medication for the allergies.	Allergies from the PPE.	
When staff members reached home, they took extra precautions before meeting their family members. (Student MF).	Fear of infecting their loved ones.	Protection of Family.	
Some ward sisters were off sick, on quarantine. Student SS)	There was high absenteeism among permanent staff	Qualified staff members were not available to supervise students	Lack of mentoring and supervision
Some permanent staff did not want students in the clinical areas. (Student SS)	Students were stigmatized as having the COVID-19 virus	Students perceived as COVID-19 carriers	
There were fewer students placed in clinical areas. (Student SK).	There were too many patients and fewer nursing staff.	Staff shortage led to work overload.	High workload
Theme 2: Clinical learning during COVID-19 pandemic			
Meaning unit	**Codes**	**Sub-categories**	**Categories**

Some educators spent only ten minutes at the patient's bedside. (Educator VM).	Scared of contracting the virus.	Limiting patient contact.	
Some educators did not go to clinical areas because they had chronic illnesses. (Educator SM).	The simulation laboratories were used for clinical teaching.	Avoiding patient contact.	Inadequate clinical teaching.
We had a challenge with clinical areas, to place our students. [Educator NN].	Clinical areas were limited	Clinical placement was a challenge	
Some educators would teach us far away from the patients' bedside. (Student PK).	Students collected necessary information from the patients' files.	Demonstration with a live patient was at times difficult.	
Some permanent staff did not want students in the clinical areas (Student SS)	Students barred from certain areas	Not all earning outcomes were achieved	Ineffective clinical learning.
Some educators would send WhatsApp messages telling us what tasks to do. (Student NM).	Students were reminded about SANC requirements	Sometimes students were on their own	
Some students went to work even after they had tested positive for COVID-19 (Student AD).	Students feared to miss out on their clinical teaching.	Student absenteeism was not remarkable.	Fixed rotational clinical placement schedule.
Theme 3: Coping strategies that can be used in future pandemics or similar crises			
Meaning unit	**Codes**	**Sub-categories**	**Categories**
Many staff members stuck to the COVID-19 protocols to survive (Student CN).	Following COVID-19 protocols was important.	Believed that being informed about the disease was crucial.	Adhering to safety protocols
Optimism helped many people to cope. (Student NM)	People believed that the pandemic would pass.	Positivism was the answer.	Positive outlook on life
Our focus was on becoming professional nurses. (Student MF).	Students displayed resilience against the pandemic.	The focus was on completing the course.	Determination to obtain the qualification.

For some people, having a strong faith in the Almighty God was the answer. (Student MF)	Having a strong faith in God.	Believed that God would protect them.	Faith in God
Some hospitals offered psychological counselling sessions. (Student SS).	People were emotionally and psychologically overwhelmed.	Counselling helped, where it was offered.	Counselling sessions
The statistics showed that not a lot of people were dying anymore, and that gave us hope (Student CN).	COVID-19 updates from National Radio and Television.	Updates from the media played a significant role.	Updated information.
New technology methods of teaching and learning are the future (Educator VM).	The use of innovative online teaching strategies.	Innovative online teaching could help during pandemics.	Use of technology.
Psychological counselling was really needed during the pandemic (Student NM).	COVID-19 vaccines were readily available.	The availability of the vaccines brought hope.	Vaccination.

4.5 Presentation of Themes and Sub-themes

Data analysis yielded three themes and 16 sub-themes, which were used as the basis for presenting findings. The first theme was clinical experiences of learning during COVID-19 and had seven sub-themes namely; clinical learning areas not accessible during lockdown, clinical hours, challenges with personal protective equipment, lack of mentoring and supervision, high workload, inadequate clinical teaching, ineffective clinical learning, and fixed rotational clinical placement schedule.

Table 4.3: Themes and categories

Theme 1	Subthemes
4.4.1 Clinical experiences of clinical learning during COVID-19	4.4.4.1 No access to clinical learning areas during lockdown
	4.4.4.2 Clinical hours
	4.4.4.3 Challenges with personal protective equipment
	4.4.4.4 Lack of mentoring and supervision
	4.4.4.5 High workload

4.5.1 Clinical Experiences During COVID-19 Pandemic

Participants were unable to practice their skills in the clinical areas due to the national lockdown that had been imposed on the whole country to curb COVID-19 infections. Therefore, participants found themselves confined to their homes.

4.5.1.1 Category 1: No access to clinical learning during lockdown

There were concerns among participants regarding their clinical training as they could not continue practicing for three months during the national lockdown, which affected all educational institutions.

> *"During national lockdown, we were in fear that the training course would be stopped! We were at home, no longer practicing and our skills would go down. I was scared that if they did not stop the course completely, they would extend it. Some of us were already repeating a year…and that was my concern, as well".* **[Student SK, Male, 30 years]**

> *"Specifically, for me, the lockdown was very difficult because I was left behind actually with the years, I was repeating due to illness. When COVID-19 came I was wondering about what's happening? I was worried because we were practicing no skills at home."* **[Student CN, female, 35 years]**

> *"During lockdown, we had a total shutdown…. we couldn't be placed at the clinical areas. We had to stay at home for three months. There was*

some online teaching though it was theory only but we did not have data to connect online." **[Student TS, female, 40 years]**

4.5.1.2: Clinical hours

Due to the break in clinical practice, participants were concerned about completing the course if they could not complete the SANC stipulated clinical hours and were scared that the course would be extended. In particular, the participants who were improving their qualifications were worried that they would return to their hospitals, still less qualified.

> *"I was worried are we going to finish our training course or what? Am I going to stay as an auxiliary nurse all my life? I enrolled for this course because I wanted to improve myself".* **[Student MF, female, 52 years]**

> *"It was very scary because we did not know what would happen concerning our training course. Are we going to get a course extension and for how long? Is it over with the course or what's actually going to happen?"* **[Student NM, female, 36 years]**

Some participants went to clinical facilities even when they had tested positive for COVID-19 because they did not want to miss out on their clinical hours.

> *"When we were called to go to clinical areas, some of us went to work even after they had tested positive for COVID-19 because they did not want to miss out on their clinical hours."* **[Student AD, female, 38 years]**

> *"Some nursing staff members had tested positive and were on quarantine. But some students who had tested positive for the virus still went to Clinical areas because most of us were scared of missing clinical hours that we were expected to meet".* **[Student MT, male, 31 years]**

> *"Some of us went on quarantine after testing positive for COVID-19, but we came sooner. We did not complete all the 14 days because we were worried about how we were going to make up missed clinical hours."* **[Student NM, female, 36 years]**

4.5.1.3 Challenges With Personal Protective Equipment (PPE)

Personal protective equipment was a major issue during the COVID-19 pandemic as it was the only available form of protection for workers against infection. As a result, it formed a big part of participants' experiences in clinical settings. PPE was unavailable or incomplete and of poor quality. Those who did not have PPE refused to work in the clinical areas, fearing for their safety.

> *"We were scared; we didn't want to work because we did not have the same PPE as the permanent staff had. In the morning, we would take report but go out thereafter and sit in one room but not work because we had no PPE*". **[Student AD, female, 38 years]**

> *"We were told that there was no PPE for students. The only PPE they had was for the permanent staff."* **[Student SW, male, 32 years]**

> *"There was no PPE for students in the clinical areas. At the hospital, we were told that there was no PPE for us, we should get it from the college. When we approached the college, we were told to go back to the hospital for PPE. We felt that nobody was taking us seriously and nobody cared about our safety. Then we were forced to go on a strike and that is only when the college started providing us with PPE."* **[Student NM, female, 36 years]**

Some participants verbalized that PPE that was provided by the hospitals was inadequate, and participants ended up buying their own masks, for example. Other participants were advised to wash their PPE so that they could wear it again. This lack of PPE led to most participants expressing fear of contracting infection and infecting their family members.

> *"The PPE was not enough for students. Sometimes, we were advised to wash the gloves and re-use them. We felt unprotected and we were scared of infecting our loved ones".* **[Student MT, male, 31 years]**

> *"Sometimes we had to repeat the PPE on the following day because we did not have enough and this made us worry about infecting ourselves. Only students, were repeating the PPE and not the permanent staff".* **[Student SW, male, 32 years]**

"It was it was quite a scary experience in a way that some of us including myself, had to go and buy our own masks so that we could be able to change on a daily basis. We wanted to protect ourselves and make sure that our families were protected too." **[Student NM, female, 36 years]**

Participants explained that it was very uncomfortable to work in PPE because the masks were suffocating them and interfered with patients understanding what they were saying as patients and colleagues could not read their lips. PPE was very hot and it made them sweat a lot. Additionally, some participants had allergic reactions to the extent of taking medications for the allergies.

"*Masks caused me to suffocate. I used to go to an empty room, remove the mask, and just draw in some air. I would then put the mask on and go back to the ward again. Communication was another challenge. It was difficult to hear what the other colleague or patient was saying to you because the speech was muffled and we could not read their lips to understand what they were saying. Social distancing made things worse because we could not come closer to each other."* **[Student SS, female, 44 years]**

"We just knew that there's a pandemic and as health workers, we were not given any in-service training in terms of how to use the PPE. So, it was really a difficult journey to adjust bearing in mind that we were also not comfortable to work with it. There was fatigue because we felt very hot and we were sweating a lot in it." **[Student SW, male 32 years]**

"*The face shield was another challenge. It was difficult to work with it on. Those who were wearing eyeglasses were having a similar challenge. They used to have fog on their glasses and they had to keep on wiping them, in order to see clearly. We could not work without it, for fear of contracting the COVID-19 virus."* **[Student CN, female, 36 years]**

Some participants were allergic to the sanitizer, which caused respiratory problems and extreme dryness of hands.

"The mask irritated me and I developed pimples on my face from that time of the pandemic, until today. Even today, I still have pimples. I hate the mask!" **[Student AD, female, 38 years]**

"My fellow students reacted from the mask and developed rash on the nose and mouth. He even had a runny nose, all the time. He had to take Phenergan tablets for the allergy and he would feel very drowsy at work. He could not be absent from work." **[Student PK, male, 31 years]**

"*COVID-19 pandemic left me with scars. I was allergic to a face mask and even now when we are many whether in classroom or in the clinical area, I suffocate and I quickly rush outside to get some fresh air. Now, I am on steroids and broncho-dilators, every day. I am sick every day, but I have to be strong in front of people."* **[Student SS, female, 44 years]**

Participants wanted to ensure that their families were protected from the virus. Some of the participants stayed at the nurses' home while others travelled daily to and from home to work. They had a fear of taking the virus home from the clinical areas. They focused on sanitizing themselves before meeting their families some of whom had chronic illnesses. They were protecting them from contracting infection. This is how they explained their routine:

"My main concern was that at home I was looking after my younger sister who is a known diabetic for years now. We were told that those with chronic conditions are more at risk of dying from COVID-19 infection." **[Student MT, female, 48 years]**

"When I knocked off from work, before entering my house I would call my daughter to bring change clothes. I would go to an outside toilet and take off my uniform and put it in a black plastic bag. I would bathe and put on clean clothes. Then, I used to soak my uniform in hot water just to kill the virus. I would sanitize myself and then enter the house. This was my daily routine; each time I came back from work." **[Student MF, female, 52 years]**

"Before leaving the ward I would sanitize everything I had, including my cell phone, pens and then when I arrived at home I would remove my

uniform and put it aside and go shower without even meeting my family. It was very difficult because sometimes it happened that I even forgot to do such a routine. The fear was too much; I didn't want to die or even infect my family." **[Student CN, female, 35 years]**

4.5.1.4 Lack of Mentoring and Supervision

Students practice clinical skills under the supervision and mentorship of qualified staff to learn the correct skills. There was a challenging shortage of permanent staff due to high absenteeism, due to fear of infection, illness, quarantine, or hospital admission. In addition, there was reluctance to mentor students, which meant that patients would not receive complete care as students worked unsupervised in most instances.

> *"Staff absenteeism was very high because some nursing staff members and students had tested positive for COVID-19 and were on quarantine".* **[Student MT, female, 48 years]**

> *"I can say absenteeism was not remarkable on the part of the students, during the pandemic. Some of the colleagues would tell you 'Me, I'm not going to work. I have kids, I have family so what if I die, but they still came to work"* **[Student CN, female, 36 years]**

> *"Absenteeism was very high on the part of the permanent staff, fewer students absented themselves from work. I know of some students who were supposed to be on quarantine but opted to come on duty."* **[Student TS, female, 40 years]**

Many participants verbalized that they were perceived by the permanent staff in the clinical areas, as a high source of COVID-19 infections. As a result, some staff members did not want students to come closer to them for fear of being infected.

> *"Some of the ward sisters did not want us to come closer to them. They said that we were going to infect them with the virus because we stay at the nurses' home and it is overcrowded. If there was something that we*

did not understand, they used to tell us to wait for our lecturers." **[Student AD, female, 38 years]**

"*The permanent staff were scared of students saying that we are at risk of transmitting COVID-19 infection because we use public transport."* **[Student CN, female, 35 years]**

"We felt very sad and stigmatized by the permanent staff. They did not want anything that had to do with us because we were carrying the virus, according to them. It was difficult even to ask them to show us anything when we were not sure because they did not want us to come closer to them." **[Student MO, male, 32 years]**

4.5.1.5 High workload

Many participants complained about a high workload due to staff shortages and the pandemic protocols such as maintenance of social distancing, allowing fewer students in the clinical areas who could share the workload.

"We were working in small numbers and the workload was unbearable because we were fewer in numbers and the patients were many. Some of the wards had been turned into COVID-19 wards and other patients were transferred to our wards, thus adding more numbers". **[Student MF, female, 52 years]**

"Social distancing meant that we would go to clinical areas in smaller numbers. This meant more work to do and we were fewer in numbers. We were getting exhausted every day because there was a lot to do and we were fewer in number." **[Student SW, male, 32 years]**

"Being at the clinical areas was the most difficult time for me because it was only a few of us. The workload was too much because some of the staff members were on quarantine or admitted to hospital. We even forgot that we were students because all we were doing was just work, work, work." **[Student NM, female, 35 years]**

Theme 2	Categories
4.4.2 Clinical learning during COVID-19 pandemic	4.4.2.1 Inadequate clinical teaching
	4.4.2.2 Ineffective Clinical Learning
	4.4.2.3 Fixed rotational clinical placement schedule

4.5.2 Clinical Learning During COVID-19 Pandemic

When students resumed clinical learning, some educator participants reported that clinical placement of students was a very big challenge because many wards had been converted to COVID-19 wards. Such wards were no longer suitable for placement of students and clinical classes would be cancelled. Therefore, learning would not take place. However, some students found themselves nursing patients with COVID-19, without their knowledge as the COVID-19 status of the patients was not disclosed or the patients were awaiting their results which could come back positive.

4.5.2.1 Inadequate Clinical Teaching

Some participants mentioned that educators were coming for periods as short as 10 minutes to teach them because they did not want to spend a long time at the patient's bedside for fear of contracting the COVID-19 virus. This further compromised student learning as they already did not receive adequate supervision from hospital staff. As a result, participants reported that sometimes clinical teaching and learning did not take place. Some educators called students to simulation laboratories to teach them skills there. However, those educator participants had a challenge when demonstrating some of the skills that needed a live patient and they sometimes ended up teaching in theory what they could have done practically. The venues were small and could not accommodate the students because they had to be mindful of maintaining social distancing.

> *"We used the simulation laboratory. I would say clinical teaching and learning was not effective because the content I was teaching needed a live patient, not a mannequin, so it was like, talking to nothing. At some*

*stage, I used to take one of the students as a patient and asked her to pretend like she had a reaction just to do a demonstration." [***Educator SM, female, 64 years]**

*"We needed to have maybe somebody acting out as a psychiatric patient, which is also not easy, especially if you've never seen a patient acting like that and therefore it was it was a problem for them. Not all educational outcomes were achieved, some yes, but not all of them." [***Educator NN, female, 53 years]**

"To be honest, there was no adequate exposure for the students during clinical placement. Some clinical areas were very small to accommodate all students. Also, the ever-changing COVID-19 protocols brought a lot of uncertainty at the clinical areas and affected teaching and learning." **[Educator VV, female, 58 years]**

4.5.2.2 Ineffective Clinical Learning

All participants reported that clinical learning was not without challenges. Clinical educators would text and tell students what educational content to cover on their own and remind them of their SANC requirements. However, practicing certain skills on their own was challenging without the guidance of clinical educators, and the ward sisters were occupied with their routines. Students would guide one another or end up not performing certain procedures on the patients because they lacked confidence. Other participants reported that some educators instructed them to collect information from a patient's file to present away from the patient's bedside. This type of learning was not very effective as there was no live patient. Participants were sometimes not allowed to enter certain clinical areas such as the operating theatre, for fear of infection.

"Clinical learning was very difficult because teaching was sometimes not happening. Some clinical educators could not actually come, instead they would send us WhatsApp messages to remind us of the SANC requirements and the procedures that we needed to do in the wards.

Sometimes, we were not confident enough to do them on the patients, without guidance from our educators” **[Student NM, female, 36 years]**

“Our clinical educators did come but not at regular times as they used to, before the COVID-19 pandemic. Also, instead of going to the patient directly, we would just take some of the information from the patients’ files and then have a lesson away from the patient’s bedside.” **[Student PK, male, 31 years]**

“Some of the nursing sisters at the clinic were willing to teach us. The challenge came when there was a patient who had tested positive for COVID-19 and they would close the whole facility for fumigation. Then we all had to go home”. **[Student MO, male, 32 years]**

4.5.2.3 Fixed rotational clinical placement schedule

Some participants mentioned that they were sharing psychiatric clinical institutions with other Nursing Education Institutions and universities on a fixed rotation schedule. Once the turn for a particular educational institution was over, it was very difficult for students who had been absent to go there, on their own, because the facility would be used by another educational institution at that particular time. Still, the educators would not be available to teach those particular students. This fixed clinical placement arrangement also forced many students not to absent themselves.

“Absenteeism on the part of the students was not much. They were willing to come to work because students wanted to make sure that learning at the clinical areas, took place. Those who were absent was because of this disease process, but very few of them.”.” **[Educator SM, female, 64 years]**

“There was some absenteeism of students, as some were isolated at home for those 14 days. Some of them did not complete the whole 14 days of quarantine because they did not want to miss their clinical hours.

Making up their missed clinical hours was a challenge for them." **[Educator VV, female, 58 years]**

Absenteeism was very high on the part of the permanent staff, fewer students absented themselves from work. I know of many students who were supposed to be on quarantine but opted to come on duty." **[Student TS, female, 40 years]**

Theme 3	**Subtheme**
4.4.3 Coping Strategies can be used in future pandemics or similar crises	4.4.3.1 Adhering to safety protocols
	4.4.3.2 Positive outlook on life
	4.4.3.3 Determination to obtain the qualification
	4.4.3.4 Faith in God
	4.4.3.5 Counselling sessions
	4.4.3.6 Updated information
	4.4.3.7 Use of technology
	4.4.3.8 Vaccination

4.5.3 Coping strategies that can be used in future pandemics or similar crises

During the interviews, participants were asked about strategies that could be used in future pandemics or similar crises to mitigate challenges faced during the COVID-19 pandemic to help them cope with the pandemic. Participants mentioned a few strategies discussed below.

4.5.3.1 Adhering to Safety Protocols

Religiously adhering to safety protocols that are put in place by scientists to mitigate the crisis or to prevent the spread of a disease.

"Sticking to safety protocols such as those given by the government relevant for the pandemic or crises being experienced in the country." **[Student SW, female, male, 32 years]**

"It is very important to adhere to the safety protocols religiously. People should not take anything for granted in the workplace, protection from infection is very important." **[Student MF, female, 52 years]**

"I am a very disciplined person, therefore I never engaged myself in many activities. Even in the future, to cope with whatever pandemic, it will be very important to take the necessary precautions, according to the instructions given about that particular disease." **[Student AD, female,38 years]**

4.5.3.2 Positive Outlook on Life

Some participants explained the importance of being optimistic about the situation one finds themselves. They reported that believing that every situation will pass, gives hope because nothing is permanent. The COVID-19 pandemic came and passed, any other crises would come and pass, and things will always change for the better.

"I always had hope that things will always get better, one day." **[Student NM, female, 36 years]**

"Believing that this too shall pass, and remaining positive gives hope that everything would be back to normal. Reminding oneself that there were pandemics in the past. So, even in the future, there will be other pandemics. It is important to remain positive and hope for the best." **[Student PK, male, 31 years]**

"One needs to be a strong-willed person who foresees good things in the future." **[Educator NN, female, 53 years]**

4.5.3.3 Determination to Obtain the Qualification

A strong determination to complete training and become professional nurses. Their focus was not much on the COVID-19 pandemic, but on their academic achievement.

> *"During the pandemic there are no options but to soldier on, in order to complete the course. Therefore, even in a similar crisis, maintaining the same attitude and soldier on"* **[Student SW, male, 32 years]**

> *"In the midst of the COVID-19 pandemic and all its challenges, one must complete the course and motivation to obtain what a student came for. Not focusing on the pandemic but focus more on what one wants to achieve in life."* **[Student AD, female, 38 years]**

> *"Having a passion for the qualification, COVID-19 pandemic is not the first pandemic and other pandemics will still come."* **[Student CN, female, 35 years]**

4.5.3.4 Faith in God

Participants emphasize their faith in God. They felt that over and above the COVID-19 protocols, God would be their hope and protector not only from the pandemic but in their day-to-day activities in life. Therefore, God remains their hope yesterday, today, and forever.

> *"Trust in God as a protector should keep one going always. As He protected me from this COVID-19 pandemic, he will also protect others from other pandemics to come"* **[Student SS, female, 44 years]**

> *"One should have strong faith to keep going, just tell yourself that God is the only one who knows about this pandemic, even in the future God will still be there."* **[Student MO, male, 32 years]**

> *"One should just tell themselves that it is only God who will protect me at the end of the day. God is there for me today and He will protect me from the future pandemics."* **[Student CN, female, 35 years]**

4.5.3.5 Counselling Sessions

Psychological counselling could help them a lot emotionally and psychologically. Spiritual support from their churches could help too.

> *"Seeing people die left, right and centre, left one emotionally and psychologically affected, counselling sessions should be available to everyone. This could really help a lot. I believe that psychological support will be essential all the time, when people are faced with pandemics or similar crises."* **[Student SS, female, 44 years]**

> *"Psychological counselling is really needed to help students; it could be from the Student Counselling department. Psychological counselling will always help in the future whenever there are similar pandemics."* **[Student NM, female, 36 years]**

> *"Psychological and spiritual support from church although physical meeting may not be possible, online sessions could be available. Other people would benefit from such help in the future, should the need arise."* **[Student PK, male,32 years]**

4.5.3.6 Updated Information

Some participants reported that obtaining updated information about the pandemic or particular crises from various sources such as National Television channels and Radio stations, that reach as many people as possible, is very crucial. Some of the information could be in the form of posters on the noticeboards and in pamphlets made available to the public.

> *"Encouraging one another and sharing whatever information will be new from the media, about pandemic or other crises. Having updated information about a pandemic or similar crisis would be of great help."* **[Student MT, female,48]**

> *"From the statistics point of view from Television and Radio, it helps to hear that not a lot of people are dying from the pandemic and this would give hope. Should a new pandemic or similar crises occur in the future, the media would come handy to help spread the updates on the latest information."* **[Educator NN, educator, 53]**

"COVID-19 updates from the media, especially National Television and COVID-19 information that was posted on the hospital notice boards and pamphlets would help for people to be well informed and would help to keep others to go on. Even in the future, the national broadcaster would be of great help to update the public about the similar crises." **[Student CN, female, 35]**

4.5.3.7 Use of Technology

Use of online teaching strategies that would involve technology to enhance clinical teaching and learning such as live videos, where the clinical educator would be demonstrating and students watching online, would be beneficial.

"I think the strategy that could really mitigate loss of time for students would be technology-enhanced strategies like using videos and simulation-based learning." **[Educator NN, female, 53]**

"I think there is a need to set up our fourth industrial revolution in education. That would bring about technological innovation in education." **[Educator AM, female, 54]**

"Venturing more into technology for teaching and employing different teaching platforms like Google workspace, Zoom, and others." **[Educator VV, 56]**

4.5.3.8 Vaccination

Prompt availability of vaccination if the crisis is infectious and could be stopped by vaccination. All participants verbalized the importance of vaccination during a crisis.

"I would encourage other students to vaccinate against the infection and encourage and motivate those who are reluctant, vaccination is very important to save lives during a pandemic. Even in the future, vaccination should be made available soon." **[Student TS, female, 40]**

"Vaccination brought hope and everybody must be encouraged to vaccinate against the infection, it gives hope. Should a similar pandemic

pounce on us in the future, vaccination would be one of the key strategies." **[Educator AM, female, 54]**

"Some institutions might want students to produce a vaccination certificate for clinical practice. For new pandemics in the future, vaccination would play an important role." **[Student CN, female, 36]**

4.6 Chapter Summary

The findings presented in this chapter have permitted a description of the student nurses' and educators' experiences of clinical teaching and learning during the COVID-19 pandemic at the Gauteng College of Nursing, according to the perspectives of participants in this study.

Importantly, the most common experiences cited by a majority of participants in this study were fear of missing out on their clinical hours and ultimately fear of not completing their training programme. The unavailability of PPE to students was identified as a major barrier to clinical learning. High staff absenteeism led to a shortage of staff and a high workload. This led to clinical areas becoming busier than normal. Students were working harder than normal, and the sisters did not have sufficient time to teach them due to the unbearable busyness of the wards. Participants reported that some staff members did not want students to come closer to them, because the permanent staff perceived that they were COVID-9 carriers as they were always doing their clinical rotations, or staying at overcrowded nurses' residences or using public transport which predisposed them to contracting the virus.

Due to all these assertions, students felt discriminated against and stigmatized by permanent staff and could not be guided well. This lack of supervision and mentoring of students by ward sisters led to ineffective clinical learning. On the one hand, the lecturers either came to teach them or came for shorter periods, because they were scared of contracting the virus. From all these experiences, participants verbalized that they could not achieve all their learning outcomes during the pandemic. All this further frustrated student participants because their

focus was more on obtaining their qualifications as competent registered or professional nurses.

CHAPTER 5: DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses the findings that were presented in the previous chapter. The discussion of the findings is based on the student nurses' and educators' experiences of clinical teaching and learning during the COVID-19 pandemic in selected campuses of the Gauteng College of Nursing.

According to Agu *et al*. (2021:1), COVID-19 affected how things were done in all walks of life including Nursing Education. When the national lockdown was put in place and students and educators had to stay at home for three months, things had to be done differently. This necessitated an urgent change in education which included a transition from on-site to remote teaching which required the use of distance-learning methods and techniques (Dziurka *et al*. 2022:1).

5.2 Overview of the research discussion

The study objectives were:

- To describe the experiences of clinical learning by student nurses during the COVID-19 pandemic.

- To explore the experiences of clinical teaching by nursing educators during the COVID-19 pandemic.

- To describe strategies that might mitigate the experiences of clinical teaching and learning during a pandemic or any similar crises.

5.2.1 Inability to Access Clinical Areas

All participants reported that they could not access clinical areas because there was a national lockdown, and the COVID-19 infections were still very high in the country. No clinical teaching could take place during this time. It was during this time that SANC decided to postpone the training at the Nursing Education Institutions (NEIs) by three months, to ensure that all the clinical requirements were met for the different nursing programmes (SANC Circular 11/2020).

All students were worried about their studies which were on halt as they could not go to practice at their respective clinical areas during the national lockdown. As a result, student nurses could not meet their clinical requirements during their current academic year, because lockdown was put at its highest level where students found themselves sitting at home and not practicing any skills. Rasmussen *et al.* (2022:4) found that participants reported experiencing anxiety, stress from isolation at home, depression as well concerns about their studies. Some student nurses felt disappointed about the absence of practical activities because they assumed such could affect their future careers, as professional nurses (Dziurka *et al.* 2022:12).

On the one hand, all student participants were worried about the acquisition of professional skills because they understood that nursing is a performance-based profession. They were concerned that by the time they went back to clinical areas, they would have forgotten the clinical skills they had learned before and they would not be able to attend to the patients adequately. This is consistent with the finding by Jamshidi *et al.* (2016:1) who explain that clinical learning environments play a critical role in the acquisition of professional abilities that train student nurses to become registered nurses. Students could not access clinical learning because of the lockdown and, therefore, no clinical learning could take place.

When the lockdown was eased and students were allowed to go back to clinical areas, they went there with mixed feelings. They were happy to go back to work, yet, they were very scared and concerned about contracting the disease. This is consistent with the findings of Pazar and Savas (2023:94) who reported that students who performed clinical practice during the pandemic had some positive experiences in terms of learning or feeling useful in the clinical areas but also experienced negative emotions such as fear and stress.

5.2.2 Clinical Hours

At the beginning of the national lockdown, some student participants were happy with the unplanned holiday but as time went on, they started getting worried and concerned about their training course as the future became uncertain. Rasmussen *et al.* (2022:4) confirm that some students expressed concerns about the impact of the pandemic on

their course progression. The focus of participants was to complete the course and qualify as professional nurses, but this dream seemed to be fading away. Some participants had joined the training course from the lower ranks of the nursing profession. Their goal was to develop themselves and upgrade their qualification so that they could complete and become professional nurses. Therefore, such students did not want to go back to their institutions of employment with the same lower qualifications.

As infections subsided, the lockdown was eased and students returned to clinical areas in smaller numbers than usual, and on alternate days to maintain COVID-19 protocols such as social distancing to prevent overcrowding. Participants were worried about incomplete SANC requirements, which threatened their progression to the next level of training. This is consistent with Swift *et al.* (2020:3112) who point out that some students were worried about completing their programmes on time and registering to practice as professional nurses. Some participants who tested positive for COVID-19 did not complete the 14 days of quarantine, and others did not quarantine at all but came to work even when they were not feeling well fearing missing out on their clinical hours, which would mean that they could not progress to the next level of training or could not graduate as professional nurses. The Nursing Act (Act No 33 of 2005), which regulates all matters concerning the nursing profession, stipulates that the clinical hours for student nurses should not be less than 60% of the entire duration of the training course.

5.2.3 Challenges With Personal Protective Equipment

Participants did not know anything about the COVID-19 disease and how to care for infected patients. They were afraid of contracting the virus and dying from it or infecting others. According to Özdemir *et al.* (2023:551) fear, anxiety, helplessness, exhilaration, and uncertainty were among the emotions student nurses reported as they entered clinical practice.

In the clinical areas, the provision of PPE was a challenge for most participants as they expected to be supplied with PPE. However, most participants reported that there was no PPE provision for students; the supply was for the permanent staff only.

Participants could not work without any protection. Ulenaers *et al.* (2021:4) affirm that the unavailability and use of PPE was an important additional stressor for students. In a few clinical areas where students were offered PPE, they were never trained on how to use it and as a result, feared that they could contract the virus from using the PPE incorrectly. Ulenaers *et al.* (2021:4) point out that students needed additional training on how to don and doff personal protective equipment.

It is important to note that participants from another campus did not have a problem with the provision of PPE in the clinical areas. The only time they had a challenge was when the hospital where they were practicing had caught fire and they were then moved to another hospital that did not have PPE for them. All participants felt that the nursing schools had to be responsible for their safety at the clinical sites, during placement. This is in line with Ulenaers *et al.* (2021:4) who mention that students relied on their nursing school to guarantee their safety during clinical placement. Furthermore, student nurses felt that nursing schools had to check whether students had access to sufficient PPE and, if necessary, provide this for their students. Participants found themselves with low-quality PPE, using the same PPE for more than a day resulting in them buying their own.

Demirdağ and Uysal (2022:26) also point out that lack of equipment and having to re-use and re-wear the same personal protective equipment many times, led to fears of being infected with the virus.

Participants felt uncomfortable working in PPE. Cengiz *et al.* (2021:2007) corroborate the experiences of the participants in this study where they reported that the PPE they were using was very uncomfortable. For example, it was very difficult to breathe with the masks on, they felt suffocated and could not communicate well with colleagues or patients because their speech was muffled. Gowns were very hot; hands were sweating from gloves and goggles were fogging thus disturbing vision. Other participants developed various forms of allergies to the PPE and had to seek medical assistance. Confirming these experiences Akkus *et al.* (2921:1253) point out that

verbal communication was a struggle due to wearing masks and hearing was also very difficult because the ears were covered.

All participants wanted to protect their loved ones from contracting the COVID-19 virus, so they made means such as taking a shower and changing their work clothes before getting in contact with family members, some of whom had chronic illnesses and were a high risk of contracting the COVID-19 infection. Pazar and Savas (2023:94), Rasmussen *et al* (2022:4), and Özdemir *et al.* (2023:552) support these findings and state that the students were found to be more afraid of infecting their elderly family members rather than catching the infection themselves.

5.2.4 Lack of Mentoring and Supervision

When participants were ordered to go back to clinical areas in very small numbers, it was in line with the COVID-19 protocols, to prevent overcrowding. Susmarini *et al*. (2022:178) concurs that some hospitals regulated practice hours and reduced student numbers for the sake of student and patient safety. While students were fewer in the wards, hospital staff members were also fewer than normal because some were infected with the COVID-19 virus and had to be quarantined and others were sick and admitted to hospital.

During this time, some clinical educators were either not coming to the wards to teach the students, or were coming for shorter periods than normal, and were not going to the patient's bedsides. As a result, students relied mostly on the ward sisters for supervision who were also either off sick or if available, were busy in the wards and did not have time to guide them. All participants felt that they were on their own as a workforce and not as students. This is in line with Demirdağ and Uysal (2022:27) where students drew attention to the lack of supervision or less supervision than normal, by senior nurses in the clinical areas. Other participants reported that they were stigmatized and perceived to be COVID carriers by hospital staff members. They said that, since they were on rotational schedules, working in various clinical areas, and using public transport where there was overcrowding, they were at high risk of contracting the virus and transmitting it to them. Akkus *et al.* (2021:1247) and Moyo *et al*. (2021:10) corroborate findings where nurses voiced out that they were stigmatized

and isolated for working in Covid-19 units, and they were also perceived as infection risks by their colleagues. Some participants found themselves allocated to clinical areas or sections of the ward where patients had COVID-19. This is confirmed by Ulenaers *et al.* (2021: 4) who reported that there was a failure or delay in informing students about potentially infected patients and infected staff by staff at the clinical areas. Participants found themselves nursing COVID-19 patients, unknowingly. Due to all these reasons, some nursing sisters did not want students to come closer to them and they were reluctant to mentor and supervise them for fear of contracting the infection.

Sometimes the educators were unable to visit students for clinical accompaniment because they were off sick or on quarantine. Participants were left with no one to guide them, and this frustrated them as they could not achieve the nursing school's expectations towards their learning objectives as they often experienced fewer learning opportunities. This was either due to changes in their clinical placement site or because their preceptor was infected with COVID-19 (Ulenaers *et al.* 2021:4).

5.2.5 High Workload

Many participants complained about excessive workload during the COVID-19 pandemic due to staff shortages, from staff members being off sick and pandemic protocols such as maintenance of social distancing allowing fewer students in the clinical areas resulting in fewer staff members sharing the workload. This is supported by Cengiz *et al.* (2021: 2006) where participants complained about excessive workloads and different working environments as nurses were sometimes redeployed to work in other units. Patients who were not infected were transferred to "non-COVID wards", which eventually became full. The participants reported that they could not cope with an unbearably high workload; there were higher numbers of patients and care was compromised for some patients. Dziurka *et al.* (2022:16) concur that students working under such conditions experienced emotional exhaustion, anxiety, and depression and this led to lower caring capacity and poorer quality of patient care. Demirdağ and Uysal (2022:26) also point out similar experiences in their study where

both nurses' and student nurses' workloads increased in intensity during the COVID-19 pandemic.

5.2.6 Inadequate Clinical Teaching

Nurse educator participants mentioned that they went to clinical areas for shorter periods, sometimes as short as ten minutes for clinical accompaniment because they did not want to spend longer times at the patients' bedsides for fear of contracting the COVID-19 virus because they had chronic illnesses and were at higher risk of contracting the infection. This further compromised student learning as they already did not receive adequate supervision and mentoring from hospital staff. Students had fewer learning opportunities. This is corroborated by Demirdağ and Uysal (2022:26) who assert that sometimes students had to work alone with no one to support them when they needed educator support.

Some nurse educator participants reported that they taught clinical skills at the simulation laboratories because they did not want to go to clinical areas. According to Dziurka *et al.* (2022:1), practical classes are held in simulation-based conditions in order to apply and deepen the acquired knowledge and professional skills. The challenge with the simulation laboratories was that not all skills could be taught there. Some skills needed a live patient and participants had to ask some students to act like patients. Sometimes participants felt that the conditions did not turn out to be conducive for adequate teaching.

Powell, Scrooby and van Graan (2020:215) argue that high-fidelity simulation be part of the curriculum of the nursing programmes. This high-fidelity simulation would enhance clinical skills development because it would integrate theory and practice. However, educators and student nurses need to be trained on how to use it, as a clinical teaching-learning method.

All participants reported that clinical placement was a challenge because clinical areas were limited. Some wards or units were turned into COVID-19 wards leading to a reduction of platforms planned for clinical learning experiences. The clinical placement programme had to be adjusted from time to time in accordance with the infection rates in the country. Clinical areas that were reduced when a patient tested positive in a

"non-COVID-19 ward" would be closed for fumigation. To concur with this finding, Dziurka *et al.* (2022:7) point out that classes were often cancelled whenever a case of COVID-19 was detected either in a student group or among patients or medical staff. Students had stress associated with uncertainty due to the outbreak of the virus in the healthcare facility and the rapidly changing COVID-19 policies. Vindrolla-Padros *et al.* (2020:5) confirm this and further state that inconsistent COVID-19 guidelines and policies created a degree of uncertainty and confusion in the workplace. Some students had to stay at home, while the clinical areas were closed because they had nowhere else to go. In support of this notion of cancellation of practical classes, Dewart *et al.* (2020:1) argue that in addition to cancelling their current clinical placement, student nurses had concerns about progressing in the rest of their programme.

Some students were placed in facilities where they did not acquire the required clinical skills because of a shortage of clinical facilities. This situation made it virtually impossible for student nurses to acquire practical skills in a clinical setting, leading to frustration and dissatisfaction (Dziurka *et al.* 2022:7; Rasmussen 2022:6).

5.2.7 Ineffective Clinical Learning

All participants mentioned that learning had transformed from what it used to be before the pandemic, because of the lack or absence of clinical accompaniment by hospital staff or college educators. To mitigate the situation, some educators would send WhatsApp messages to students with instructions on tasks and remind them about the importance of meeting their SANC requirements. At times, student nurses found themselves doing nursing procedures without supervision and guiding one another. Assistance from hospital staff was not guaranteed as they were too busy with ward routine or they would simply tell them that they should wait for their educators to teach them. This led to students neglecting to perform certain procedures as they were scared to make mistakes. Demirdağ and Uysal (2022:27) agree that students' insufficient knowledge of clinical skills caused low self-confidence and fear of making mistakes. Student nurses also felt disappointed about the lack of practical activities because they assumed that this could affect their future careers (Dziurka *et al.* 2022:12).

At times students were asked to collect information from the patient's file and educators would come and teach them away from the patient's bedside, which was inadequate as a procedure technique could not be demonstrated on the patient. This finding is corroborated by Dziurka *et al.* (2022:8) where the students also mentioned that some practical classes were conducted away from the patients in a situation that could not be practical enough for the students to understand the content. For example, where they needed to perform a procedure on a live patient, this could not happen.

Furthermore, this, in their opinion, replaced practical classes with procedures or nursing processes which would not compensate for real-life work in a healthcare facility. According to some participants in this study, some clinical areas were small in size, especially at the clinics, and could not accommodate a few students allocated there. This challenge of overcrowding in the clinical areas made it difficult for both clinical supervisors and student nurses to have a meaningful engagement (Ziba *et al.* 2021:2). Therefore, students did not have optimum learning opportunities.

There are those participants who could not learn because they were barred from accessing some clinical areas such as the operating theatre by medical doctors and nursing sisters for fear of spreading the infection. In line with this experience, Dziurka *et al*. (2022:7) reported that some students felt a lack of acceptance and support from their clinical mentors and medical personnel in the clinical setting where training took place.

5.2.8 Fixed Rotational clinical placement schedule

All participants agreed that students' absenteeism was not remarkable in the clinical areas during the pandemic, because many students did not want to be absent from work. Even though the participants were scared of contracting the virus, they were more scared of missing out on their SANC requirements. Their focus was more on completing their training, which was not going to be possible if they had incomplete clinical hours and stipulated clinical procedures for each discipline or module for the training programme. All participants mentioned that they wanted to complete their training course and, therefore, kept to the placement schedule. Similar sentiments are

evident in Rasmussen *et al.* (2022: 4) where participants expressed their concerns about the impact the COVID-19 pandemic could have had on their course progression, as they wanted to complete their training successfully.

Nursing student participants went to work even when not feeling well or after having tested positive for the COVID-19 virus. A few of them were in quarantine, but some of them came back to work before completing the stipulated 14 days at home. Participants explained that they were scared of losing their scheduled time at a specific unit or institution since they shared clinical facilities with other Nursing Education Institutions and universities, on a fixed clinical rotation schedule. It would be hard for them to catch up because the next turn was for another institution.

5.3 Strategies to Be Used in the Future

The participants suggested the following strategies to be used, should similar pandemics or similar crises occur in future.

5.3.1 Adhering to Safety Protocols

All participants verbalized that adhering to safety protocols such as social distancing, wearing a mask, and sanitizing hands would help to mitigate the crisis. All participants kept practicing the latest information that they received. All participants believed that safety protocols and guidelines from the health scientists would help to prevent the spread of a disease even in the future.

5.3.2 Positive Outlook on Life

For many participants, they verbalized that having a positive attitude was the answer. According to Rosmawati and Rantung (2023:854), having a positive outlook would be crucial for practicing in clinical settings during the COVID-19 pandemic. Furthermore, having a positive mindset could affect one's immunity positively. Many participants believed that all pandemics come and go and, therefore, COVID-19 would also go away, and life would go back to normal again. The belief that nothing is permanent made many participants view life in a very positive light, as time went on and helped them to cope. Dziurka *et al.* (2022:11) mention that some students suggested that the

strategy to cope with this unusual and difficult situation in future is composure and inner calm.

5.3.3 Determination to Obtain the Qualification

Another strategy that was apparent among the students was a shift from thinking about the pandemic and focusing on completing their training courses and graduating as professional nurses. To support this recommendation Rasmussen *et al* (2022:4) state that what was a positive finding is that participants reported increased resilience, they found inner strength while they were dealing with their condition in a rapidly changing situation. This is the very same resilience that student nurses need to have in the future to cope with pandemics and other similar situations, going forward.

This determination is also evident in the way students went to work even when they were not feeling well because they did not want to be left behind with their training course. Their sole purpose was to complete the course and become professional nurses.

5.3.4 Faith in God

Many participants in this study expressed that they believed that God would protect them, and they put an emphasis on their faith in God. They mentioned that they felt that over and above the COVID-19 protocols, God was their hope and protector not only from the pandemic but in their day-to-day activities in life. In a study conducted by Ruvalcaba *et al.* (2023:6), this coping strategy of putting trust in God was verbalized by many participants, especially women who believed that prayer and involvement with churches was and will always be a major coping mechanism for people. Furthermore, they were even quoted saying “God is in control; life and death come from God” amid the uncertainty caused by the pandemic. Rosmawati and Rantung (2023:855) and Alshagrawi (2023:8) also allude to this notion of having faith in God by saying the strategy that will always be used by participants to deal with anxiety when carrying out practice during the pandemic would be through prayer which was acknowledged as a way to nurture their spiritual well-being. They further explained that according to the participants, praying could reduce the anxiety they felt. Therefore,

putting faith in God remains the coping strategy for some people yesterday, today, and forever.

5.3.5 Counselling Sessions

Many participants in this study mentioned that there were clinical areas that offered counselling sessions for all staff members, including students and there were those clinical areas that offered counselling sessions to their permanent staff only and students were not accommodated. In line with these findings, Ulenaers *et al*. (2021:4) state that psychological assistance did not always include students at the clinical sites. However, those participants who had access to counselling sessions reported that it helped, where it was offered. Educator participants who were teaching students at the clinical sites during the pandemic reported that they did not receive any counselling from either the college or the hospital, as the counselling support that was available at the hospital was for the permanent hospital staff only. One participant mentioned that he received spiritual support from his pastor from his church and it was very effective, in the sense that all his fears about the pandemic were dispelled.

This means that even in future crises, counselling sessions will always be necessary to help people cope with the crises. Some participants mentioned that they were sharing their experiences with their families and the support they received from them made them feel better and stronger. Alcalá-Albert *et al.* (2022:8) alluded to this notion by saying that sharing their experiences with their loved ones helped them have a sense of relief; it was their support tool. Furthermore, other students commented that going on therapy really helped them better manage their anxiety levels during clinical placement. In line with this counselling support, Xu *et al* (2021:6) state that nursing colleges and teaching hospitals can set up special psychological intervention teams and provide convenient psychological support for clinic student nurses through group psychology to help improve their confidence and abilities to actively respond to the epidemic. Training courses for educators and students, teaching them about various strategies for coping and training courses on strategies for coping with stress and anxiety, ethical problem solving, and decision-making during a pandemic or similar crises, would help.

5.3.6 Updated Information

Participants in this study received COVID-19 information from the media; national TV and Radio and it played a significant role in updating them about the disease. Some participants also read the information on the hospital notice boards. There were meetings for staff at the hospital where the staff was kept updated, unfortunately, students were not allowed in those meetings. Consistent with these findings, are Demirdağ and Uysal (2022: 23) who argue that students lacked information as they were not part of the meetings when the permanent staff had meetings. This corroborates the findings in this study where some participants mentioned that when they heard from the National Radio and Television that the statistics of people dying from the disease were coming down, it brought a lot of relief and hope. Therefore, the use of mass media will always play a big role in updating people about a crisis and helping them cope.

5.3.7 Use of Technology

Some participants in this study recommended the use of online teaching strategies that would involve technology to enhance clinical teaching and learning such as live videos. In this way, while the clinical educator would be demonstrating, the students would be watching online. Participants stressed that innovative online teaching would help during pandemics.

According to Rasmussen *et al.* (2022: 4) some participants identified a period to adjust to new modes of teaching and learning which were introduced as a response to physical distancing and social restriction in the education of nurses. Furthermore, they highlight the need to introduce students to clinical practice that is based on current medical knowledge and modern technologies such as medical simulation, telemedicine, and virtual reality which would ultimately help to mitigate the gap between theory and practice. On the one hand, Powell, Scrooby and van Graan (2020:215) recommend that high-fidelity simulation be part of the curriculum of the nursing programmes, and that nurse educators and students be trained on how to use it as a clinical teaching-learning method. Furthermore, this high-fidelity simulation would enhance clinical skills development through theory-practice integration, and as a result, lead to better patient safety. On the other hand, Hargreaves *et al* (2021:7)

argue that clinical settings that incorporate telenursing will help prepare students for the future of nursing. They also believe that when the epidemic recedes, students will become competent in hands-on skills as they return to clinical settings or when they are hired as registered nurses (Hargreaves *et al* 2021:7).

5.3.8 Vaccination

All participants in this study agreed that the availability of vaccines brought hope to the people, especially the healthcare workers on the frontline. If the crisis is infectious and could be stopped by vaccination, then it is one of the coping strategies. The availability of the vaccines brought hope to many. Dziurka *et al.* (2022:9) concur with this, they further state that the risk of infection further decreased when vaccinations were made available. Furthermore, it was only then that the students felt protected to some extent. Therefore, vaccinations against a pandemic will always be one of the coping strategies against possible infections.

5.4 Conclusion and Summary

This study exposed the lack of preparedness of the college and the clinical areas to handle a pandemic crisis of that magnitude. During the hard lockdown when students and educators were at home for three months, there was no clinical teaching taking place because the Nursing Education Institution did not have the necessary technical skills and capacity to teach students online. When the lockdown had been eased and students were allowed to go back to clinical areas, clinical placement was a huge challenge because they did not have sufficient clinical areas to place students. Everybody was gripped with fear of contracting the virus, infecting others, infecting their loved ones at home, and even dying from it. The lack of PPE for students was another challenge because the responsibilities were unclear between the college and the clinical areas as to who was responsible for providing them with the PPE; the college and hospital could not take the responsibility. The lack of provision of human, financial, and material resources from the colleges, hospitals, and clinics needed the involvement of the Ministries of Education and Health, to ensure that necessary resources are available.

CHAPTER 6: SUMMARY OF FINDINGS, LIMITATIONS, FURTHER RESEARCH AND RECOMMENDATIONS

6.1 Introduction

In the previous chapter, the study findings were discussed in relation to the objectives of the study. This is the last chapter of the study which comprises the findings, a discussion of the study limitations as well as recommendations arising from the findings. Through the literature review, the researcher was able to identify other research studies that support or corroborate her findings as well as those that differed from her findings.

6.2 Summary of Findings

The findings of this study have shed some light on the experiences of student nurses and clinical educators in clinical placements during the COVID-19 pandemic. Both students and educators were anxious and stressed about getting infected by the COVID-19 virus. The educators were even more stressed because they were older as compared to the students and were more concerned about their chronic illnesses which made them more susceptible to the disease. On the one hand, the students were more exposed to the disease because they spent longer times with the patients in the clinical areas than their educators.

The students were not provided with PPE by either the college or the hospitals and clinics where they were placed. The college assumed that the clinical areas would provide students with PPE because they were under their care during clinical placement yet, the clinical areas believed that it was the responsibility of the college to provide students with PPE and ensure their safety during clinical placement. However, the clinical educators never had a challenge with the provision of PPE because the college provided for them. Student nurses felt that they did not receive sufficient support, whether it was emotional or educational, from the permanent staff at the clinical areas. Some felt abused when they were made to nurse COVID-19 patients without their knowledge. Most student nurses strongly felt that the permanent staff did not care about their safety.

Some students had access to psychological support in the clinical areas, though not all clinical areas offered such services to students, it was meant for their permanent staff. There was no provision of such services for the educators in the clinical areas and at the college.

Both educators and students experienced challenges with the use of PPE. For example, there was fogging from the visors and irritation from the masks, but the students experienced them more because they spent more time working in the clinical areas and educators spent less time there.

The clinical placement was stressful for both student nurses and educators but from different perspectives. The educators were stressed about how to allocate fewer students to clinical areas but still ensure clinical exposure for all of them within a given time. The challenge was that clinical sites were insufficient for clinical placement because they had been reduced due to the fact that some of them had been turned into COVID-19 wards. Educators had to frequently adjust their clinical allocation schedule which kept on changing as soon as there were new COVID-19 cases diagnosed. The clinical sites had to be closed for fumigation and teaching, therefore learning did not take place during that time. The educators had to reallocate students at a later stage and time was not on their side because the main timetable was fixed for theory and clinical, yet the clinical sites were also shared with other institutions. Once each institution's allocated time was over, there could not be any further allocation of students at those clinical institutions. Furthermore, the students were frustrated in the sense that they did not learn when the clinical sites were temporarily closed due to COVID-19 infections and there were no alternative clinical sites to go to because students were many and sites were few, they simply had to stay at home. Sometimes student nurses were taught at the simulation laboratories, when clinical sites were unavailable. The challenge with simulation laboratories was that sometimes the procedures needed a live patient for demonstration and that was another challenge for both students and educators. All students were worried about completing their training course and as a result, they went to the clinical areas even when they had tested positive for COVID-19, which put their lives and the lives of their patients and colleagues at risk. The fact that educators were unable to teach effectively and the fact

that students could not learn effectively affected all of them negatively, albeit in different ways.

All students and educators were offered COVID-19 testing as well as vaccinations. The services were equally available to all of them. It was very interesting to note that all participants had various issues with the PPE. They all experienced discomfort in different ways. Some had challenges with the face masks, others with the visors, gloves, gowns, sanitizers, and more. Additionally, almost all participants had issues with the PPE.

It is hoped that the findings of this study will provide insights into how to plan appropriately for any pandemics or health crises that could occur in the future. Appropriate training of health personnel on how to handle pandemics and timeous procurement of PPE and other material resources would prevent the loss of more lives in the future. It was apparent that the hospitals, clinics, and nursing educational institutions were not ready to address the pandemic. To affirm this notion of not being prepared for the pandemic, Moyo *et al.* (2021:13) maintain that there was a lack of preparedness by hospitals and health facilities to deal with the COVID-19 pandemic.

6.3 Limitations of the Study

The participants in this study were fourth-year student nurses and their clinical educators were from two campuses in Johannesburg. This being a qualitative study, the sample size was small, and therefore, the results cannot be generalized to other student nurses and clinical educators. Most of the students were female, and all educators were females. The number of males in this study was insufficient to make gender comparisons.

The study sample included only R425 students, other students outside these criteria and other campuses were excluded. Therefore, they could have come up with different experiences if they were in clinical placement during the pandemic.

6.4 Recommendations from Findings

The following recommendations are presented to attempt to address the gaps that were identified by this study.

6.4.1 For the Gauteng Ministry of Health

The Ministry of Health ought to ensure that there is a sufficient budget allocated to the Gauteng Hospitals and clinics to extend the existing units as they are too small for students to practice. This would benefit the department by producing well-rounded professional nurses to serve the Department of Health. These units are shared among student nurses, medical students, and clinical psychology students from local NEIs and universities, consequently there is overcrowding.

The Gauteng College of Nursing needs to allocate a budget for the NEIs to buy high fidelity simulation and to ensure that there is a budget allocated for NEIs to train educators on how to use them, as these could be useful in case of another pandemic or similar crisis.
They should also allocate a sufficient budget to procure PEE for student nurses and staff.

6.4.2 For The South African Nursing Council

The SANC ought to develop policies that would be used by NEIs during challenging times of pandemics or any crises that may arise and affect nurse training. These policies need to address and regulate online clinical teaching specifically when making use of high-fidelity simulation because the nursing profession is 60% practical. Such policies should take into cognizance that incomplete clinical hours mean an incomplete qualification. For example, such policies should allow student nurses to complete their practicals under supervision even when they are already practicing as qualified nurses. The policies for nursing training should include pandemics and disaster management.

6.4.3 For the Gauteng College Management

The college management should prepare for disasters such as pandemics. They should come up with policies on how the Nursing Education Institutions would procure their material resources, for example, the PPE. The college should allocate a budget to procure sufficient PPE for their staff and have some for students on standby, just in case students do not get enough from the clinical areas to avoid a situation where students buy their own, with their own money.

There should be communication between the college management and the hospital management to plan and agree on clinical matters, pertaining to the welfare and safety of the students during clinical placement if there is a pandemic or similar crisis.

There should be an effective mechanism for managing complaints of the students and educators, by the college management in the clinical areas. For example, the management ought to be involved in clinical placement during pandemics. This responsibility should not be left solely at the hands of educators alone to use their discretion during this challenging time.

The college management should support staff members and students who get infected and affected by a pandemic so that they feel comforted and supported during a pandemic. The college management should ensure that counselling services are available to offer psychological support to clinical educators during a pandemic, should they become emotionally affected and overwhelmed, they also need to de-stress, like all affected people.

Educators should be trained on the appropriate use of high-fidelity simulation mannequins to enable them to teach the students online, during a pandemic or any other crisis that would make it imperative for students to be away from clinical areas.

6.4.4 For the Hospital Management

The healthcare service managers need to work together with the college as far as the availability of clinical areas is concerned.

Hospitals ought to take the presence of student nurses into cognisance when procuring supplies and PPE and should also make it a priority that it is of a good standard in terms of quality and sizes.

The hospital management ought to ensure that student nurses are part of the teams whenever information that relates to the pandemic is shared. For example, updates about the disease, safety protocols, testing for the virus, and counselling services are shared. In addition, the management is advised to allocate a budget for such services and make them available to all staff including students, 24 hours a day.

The hospital management should encourage in-service training of staff that focuses on policies that emphasize Human Rights and prevent discrimination against student nurses in the workplace.
The hospital management ought to allow students to work even during weekends and holidays, to meet their SANC requirements, if the clinical areas are not available to accommodate all of them during the week.

Health service managers have a duty to manage resources that are allocated to them, including human resources. They need to analyze working conditions and ensure equal and fair distribution of staff in such a way that all areas of the health facility are covered, to prevent some staff from being overworked.

There should be training courses for all staff, teaching them about various strategies for coping, and training courses on strategies for coping with stress and anxiety, ethical problem-solving, and decision-making during a pandemic or similar crisis.

6.4.5 For Healthcare Workers

The unit managers should ensure that there is a good relationship between clinical staff and students. They ought to work as a team and the clinical staff needs to accept them as part of the team. The clinical staff should always be reminded that the students are there to learn and are not there as an additional workforce.

The unit manager ought to make sure that that there is sufficient in-service training on infection control and staff, including students, are trained on how to don and doff personal protective equipment. The staff members should be aware of any new guidelines in the units so that they are on par with the crucial information, especially about pandemics.

Communication is crucial. Arrangements ought to be made between the nursing college and clinical facility for student nurses to complete hours in areas where they could not complete them. They can work in another area while they cannot access others to save time.

6.4.6 For Clinical Nurse Educators

Educators must report to the college management if they are not in a position to carry out their duties in the clinical areas so that the management can make other arrangements. Educators must, as much as possible, ensure that they protect themselves with PPE to teach students at the patient's bedside for effective clinical teaching.

6.5 Recommendations for Further Research

This is a qualitative study that addressed a small group of participants. The findings of the study are not intended to be generalized but to explore the experiences of the student nurses and educators during the COVID-19 pandemic, concerning their clinical teaching and learning.

Hence, this study could stimulate higher education institutions to conduct similar studies in other contexts to obtain a more thorough understanding of this matter. Therefore, further studies are still needed to explore the experiences of other groups of students and educators during a pandemic.

6.6 Conclusion

In summary, to have a less challenging clinical placement of students during a pandemic requires a concerted effort directed at supporting a change of attitudes and behaviours as well as improving the support of students and their clinical educators during a crisis or a pandemic. From the findings of this study, clinical educators experienced some challenges during the pandemic. However, student nurses suffered a lot of challenges such as humiliation, abuse, discrimination, and stigmatization in the workplace during clinical placements. The most reassuring aspect of this whole experience is that they were resilient and goal-directed and refused to be distracted from their goal of completing their training course. It is hoped that these experiences will help shape how the authorities become highly prepared and proactive in their planning to promote and improve the clinical teaching and learning environment during a crisis such as COVID-19.

Nursing clinical educators should use the findings of this study during curriculum development to include innovative strategies of clinical teaching and learning during clinical practice, using their experiences during the COVID-19 pandemic.

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APPENDICES

Appendix A - Letter of information

LETTER OF INFORMATION

Title of the Research Study: Student nurses and educators' experiences of clinical teaching and learning during COVID-19 pandemic in selected Gauteng College of Nursing.

Principal Investigator/s/researcher: Zandile Goodness Malindisa, Master's in Nursing

Co-Investigator/s/supervisor/s: Dr. D.G. Sokhela: D Nursing and Professor S.T. Ngxongo: D Nursing

Brief Introduction and Purpose of the Study:

My name is Zandile Malindisa. I am conducting a research project on the above-mentioned topic. Iwould like to invite you to participate in this research study. The aim of the proposed study is to explore student nurses and educators' experiences of clinical teaching and learning during COVID-19 pandemic in selected Gauteng College of Nursing.

Outline of the Procedures: I aim to conduct the interviews following the interviewing process. If you agree to participate in the study, I will conduct face-to-face semi-structured interviews at the time and venue that you choose. The interview should take about 30 to 45 minutes may be longer depending on how much information you are willing to give. You will be allowed to ask for clarity if the question asked is not clear to you**.**

Risks or Discomforts to the Participant: There is no anticipated risk or discomfort that you may experience from the study.

Benefits: All participants will benefit from this research since the purpose of this study is to explore the student nurses and educators' experiences of clinical teaching and learning during COVID-19 pandemic in selected Gauteng College of Nursing. Therefore, you will find an outlet to speak freely with your experiences which you may not have been able to voice out.

Reason/s why the Participant May Be Withdrawn from the Study: It is very important for you to know that yourparticipation in this study is voluntary. Should you feel uncomfortable or no longer interested, you may withdraw at any time from this research project, with no negative consequences.

Remuneration: Your contribution towards this research would be very important, but please note that there will be no monetary gain from participating inthis research study.

Costs of the Study: Please note that you will not pay anything or lose anything for participating in this project. I will come to you at the venue that you choose.

Confidentiality: To protect your confidentiality, pseudonyms will be used. Collected data will only be accessible to the researcher and supervisors to protect

respondents' right to confidentiality. Electronic data will be password protected and hard copies will be locked in a safe cabinet which is accessible only to the researcher and supervisors. After the completion of the study, the collected data will be kept for five years and thereafter deleted from the computer and hard copies destroyed.

Research-related Injury: Only interviews will be collected, as such no injury is envisaged.

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

(Supervisor and details) Please contact the researcher on 073 714 2701, my supervisor on 031 3732606, or the Institutional Research Ethics Administrator on 031 373 2375. Complaints can be reported to the DVC: Research, Innovation and Engagement Prof S Moyo on 031 373 2577 or moyos@dut.ac.za.

Appendix B – A Consent Form

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Zandile Goodness Malindisaabout the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: **IREC 309/22**
- I have also received, read and understood the above-written information (Participant Letter ofInformation) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date ofbirth, 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 beprocessed in a computerized 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 toparticipate in the study.
- I understand that significant new findings developed during the course of this research which mayrelate to my participation will be made available to me.

______________________ ___________ ______ ________________

Full Name of Participant **Date** **Time**

Signature

I, Zandile Goodness Malindisa herewith confirm that the above participant has been fully informed about thenature, conduct and risks of the above study.

Zandile Goodness Malindisa ____________ ______________________

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

____________________ ____________ ______________________

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

__________________ __________ ____________________

Full Name of Legal Guardian (If applicable) Date **Signature**

Appendix C1 - Interview Guide for Student Participants

Interview Guide for student Participants

Date: **Time:**

College Code: **Participant Pseudonym:**

Section A: Demographic Information

Age ☐

Gender ☐

Marital Status**:** ☐

Section B: <u>Interview Question</u>

Grand tour question

During the Covid-19 pandemic, there were many patients who were infected in this province and some wards were converted to become Covid-19 wards. There were

COVID-19 protocols which included social distancing which forced students to go to clinical placement in small groups.

1. Tell me about your experiences of clinical learning and placement during the COVID-19 pandemic.
2. How did you react to the new situation of the Covid-19 pandemic that you found yourself in?
3. How did you perceive the Covid-19 pandemic as an individual/own self?
4. Explain your positive attributes during the Covid-19 pandemic.
5. What support did you receive in clinical learning and placement during the COVID-19 pandemic from your educators or management?
6. What strategies do you think might mitigate the experiences of clinical teaching and learning during a pandemic or any similar crises?
7. What strengthening resources were available for you in the workplace?

Probing where necessary

"Tell me more about……….."   "How did that make you feel……….?"

Appendix C2 - Interview Guide for Nurse Educator Participants

Date: **Time:**

College Code: **Participant Pseudonym:**

Section A: Demographic Information

Age

Gender

Marital Status**:**

Section B: Interview Question

Grand tour question

During the Covid-19 pandemic, there were many patients who were infected in this province and some wards were converted to become Covid-19 wards. There were Covid-19 protocols which included social distancing which forced students to go to clinical placement in small groups.

Follow up questions

1. Tell me about your experiences of clinical learning and placement during the COVID-19 pandemic.
2. How did you react to the new situation of the Covid-19 pandemic that you found yourself in?
3. How did you perceive the Covid-19 pandemic as an individual/own self?
4. How did you manage with clinical teaching during the Covid-19 pandemic?
5. Explain your positive attributes during the Covid-19 pandemic.
6. What support did you receive in clinical teaching during the COVID-19 pandemic from your management/organisation?
7. What strategies do you think might mitigate the experiences of clinical teaching and learning during a pandemic or any similar crises?
8. What strengthening resources were available for you in the workplace?
   Probing where necessary

   "Tell me more about……….."   "How did that make you feel……….?"

Appendix D - A Research Poster

You are invited to participate in research

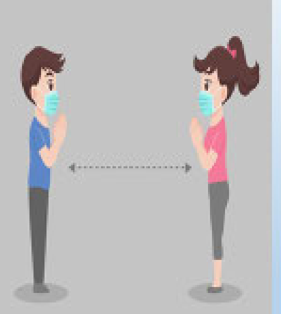
Topic: Student nurses and educators' experiences of clinical teaching and learning during COVID-19 pandemic in selected campuses of Gauteng College of Nursing.

Where? At the Nurses' Residence

When? 31st March 2023 – 31st May 2023,
17h00 & 19h00 [Between Monday and Thursday]
(Whenever suitable and available)

How long is the interview? : 30 minutes

Head Researcher :Zandile Malindisa (Candidate for Master's in Nursing)
Durban University Of Technology
☎ : 073 714 2701



Assistants :
Nandi Ndaba (Lecturer) ☎ : 061 7278710
Millicent Diphologi (Lecturer) ☎ : 078 3134564

For Master's in Nursing, Durban University of Technology,
Department of Health Sciences

Appendix E – An Introduction to Research Ethics Certificate

Zertifikat

Certificat

Certificado

Certificate

Promouvoir les plus hauts standards éthiques dans la protection des participants à la recherche biomédicale
Promoting the highest ethical standards in the protection of biomedical research participants

TRREE

Clinical Trials Centre
The University of Hong Kong

Certificat de formation - Training Certificate

Ce document atteste que - this document certifies that

Zandile Goodness Malindisa

a complété avec succès - has successfully completed

Introduction to Research Ethics

du programme de formation TRREE en évaluation éthique de la recherche
of the TRREE training programme in research ethics evaluation

Release Date: 2021/10/18

Professeur Dominique Sprumont
Coordinateur TRREE Coordinator

FMH Continuing Education Program (5 Credits)
Programme de Formation continue (5 Crédits)

Foederatio Pharmaceutica Helvetiae FPH Programmes de formation continue
Continuing Education Programme
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[REV : 20170310]

Appendix F1: Provisional Approval letter from DUT – IREC

Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Berwyn Court
Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

17 February 2023

Ms Z G Malindisa
211 Boswell Avenue
Mondeor
Johannesburg
2091

Dear Ms Malindisa

Student nurses and educators' experiences of clinical teaching and learning during COVID-19 pandemic in selected campuses of Gauteng College of Nursing

I am pleased to inform you that **PROVISIONAL APPROVAL** has been granted to your proposal subject to:

- Piloting of the data collection tool. *Please note that should there be any changes to the data collection tool, in a letter signed by the researcher and supervisor, list the changes to the documents and submit to DUT-IREC with the final data collection tool. Even when there are no changes to the data collection tool, DUT-IREC has to be notified.*
- Obtaining and submitting the necessary gatekeeper permission/s to DUT-Institutional Research Ethics Committee (DUT-IREC).

PLEASE NOTE THAT THIS IS NOT A FINAL APPROVAL LETTER. KINDLY SUBMIT THE ABOVE MENTIONED DOCUMENTS WITHIN THREE MONTHS TO THE DUT-IREC OFFICE. DATA COLLECTION CAN ONLY COMMENCE WHEN DUT-IREC ISSUES FULL APPROVAL

The Proposal has been allocated the following Ethical Clearance number **IREC 309/22**. Please use this number in all communication with this office.

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

Yours Sincerely

Prof J K Adam
Chairperson: DUT-IREC

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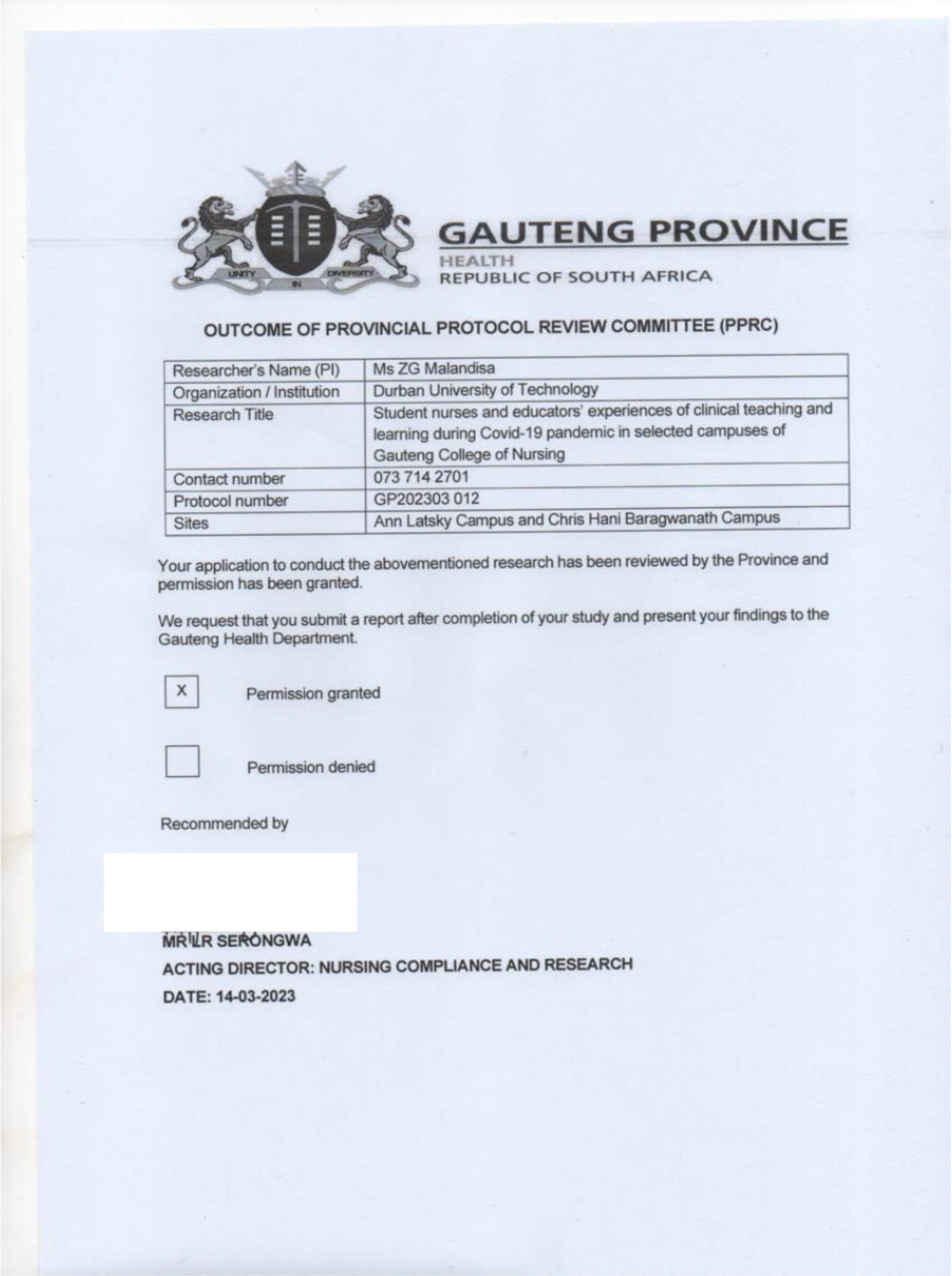
fairness • professionalism • commitment • compassion • excellence

Appendix F2: Approval Letter from Provincial Protocol Review Committee



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

OUTCOME OF PROVINCIAL PROTOCOL REVIEW COMMITTEE (PPRC)

Researcher's Name (PI)	Ms ZG Malandisa
Organization / Institution	Durban University of Technology
Research Title	Student nurses and educators' experiences of clinical teaching and learning during Covid-19 pandemic in selected campuses of Gauteng College of Nursing
Contact number	073 714 2701
Protocol number	GP202303 012
Sites	Ann Latsky Campus and Chris Hani Baragwanath Campus

Your application to conduct the abovementioned research has been reviewed by the Province and permission has been granted.

We request that you submit a report after completion of your study and present your findings to the Gauteng Health Department.

[X] Permission granted

[ ] Permission denied

Recommended by

MR LR SERONGWA
ACTING DIRECTOR: NURSING COMPLIANCE AND RESEARCH
DATE: 14-03-2023

Appendix F3: Approval letter from ALC

Ref no: 03032023
Enquiries: Ms M. Ndlela
Telephone Number: 011 644 8951
Email: Mavis.Ndlela@gauteng.gov.za

TO : MS Z.G. MALINDISA

SUBJECT : APPROVAL FOR RESEARCH DATA COLLECTION

RESEARCH TITLE : STUDENT NURSES AND EDUCATORS' EXPERIENCES OF CLINICAL TEACHING AND LEARNING DURING COVID-19 PANDEMIC IN SELECTED CAMPUSES OF GAUTENG COLLEGE OF NURSING

NHRD NUMBER : GP202303 012

Dear Ms Malindisa

Thank you for showing an interest in collecting data at our campus of Gauteng College of Nursing. The campus Research Committee has met and reviewed your application for data collection. Your request to collect data at the Campus is granted by the Principal of Gauteng College of Nursing

Please take note of the following:

- The office of the Principal of GCON wishes to inform you that permission for data collection at **Ann Latsky Campus**_has been granted as all documents required has been submitted.
- The research committee of GCON would like to schedule a discussion on tentative dates and times.
- Should you not be able to honor the scheduled appointment, you are required to inform the relevant campus/ institution within 48 hours.
- All information and data collection should be treated as confidential and ethical considerations adhered to as stated in the proposal.
- All data collected from the institution will be treated as confidential and purely for academic purposes etc.
- Failure to adhere to ethical principles the GCON Research Committee will revoke the permission to collect data and report to the GCON Ethics Committee.

- The name of the organization will not be mentioned in the research report.
- Upon completion of your research study, kindly furnish the GCON with the study results and a copy of your Dissertation/ Thesis for the Institutional repository.
- The research committee may invite you to present the study during the annual research day.
- You will be expected to present your study findings at a GCON event.

We hope you will comply with the terms and conditions of collecting data in the institution

Sincerely yours.

Signature:

Ms. M. Ndlela
GCON Research Committee Chairperson

Date: 22/03/2023

Signature:____

Ms P.L. Mohoaduba
Campus Head: Ann Latsky Campus

Date: 22.03.2023

Approved: __

Ms. N.D. Gidimisana
Director: GCON

Date: 24/03/2023

Appendix F4: Approval letter from CHBC

Ref no: 03032023
Enquiries: Ms M. Ndlela
Telephone Number: 011 644 8951
Email: Mavis.Ndlela@gauteng.gov.za

TO : MS Z.G. MALINDISA

SUBJECT : APPROVAL FOR RESEARCH DATA COLLECTION

RESEARCH TITLE : STUDENT NURSES AND EDUCATORS' EXPERIENCES OF CLINICAL TEACHING AND LEARNING DURING COVID-19 PANDEMIC IN SELECTED CAMPUSES OF GAUTENG COLLEGE OF NURSING

NHRD NUMBER : GP202303 012

Dear Ms. Malindisa

Thank you for showing an interest in collecting data at our campus of Gauteng College of Nursing. The campus Research Committee has met and reviewed your application for data collection. Your request to collect data at the Campus is granted by the Principal of Gauteng College of Nursing

Please take note of the following:

- The office of the Principal of GCON wishes to inform you that permission for data collection at **Chris Hani Baragwanath Campus** has been granted as all documents required has been submitted.
- The research committee of GCON would like to schedule a discussion on tentative dates and times.
- Should you not be able to honor the scheduled appointment, you are required to inform the relevant campus/ institution within 48 hours.
- All information and data collection should be treated as confidential and ethical considerations adhered to as stated in the proposal.
- All data collected from the institution will be treated as confidential and purely for academic purposes etc.

GCON/ Research Permission Letter

1

- Failure to adhere to ethical principles the GCON Research Committee will revoke the permission to collect data and report to the GCON Ethics Committee.
- The name of the organization will not be mentioned in the research report.
- Upon completion of your research study, kindly furnish the GCON with the study results and a copy of your Dissertation/ Thesis for the Institutional repository.
- The research committee may invite you to present the study during the annual research day.
- You will be expected to present your study findings at a GCON event.

We hope you will comply with the terms and conditions of collecting data in the institution

Sincerely yours.

Signature ______________________

Ms. M. Ndlela
GCON Research Committee Chairperson

Date: 22/03/2023

Signature: PP ______________________

Ms. P.C. Sithole
Campus Head: Chris Hani Baragwanath Campus

Date: 23/03/2023

Approved

Ms. N.D. Gidimisana
Director: GCON

Date: 24/03/2023

Appendix F5: Full Approval letter from DUT - IREC

Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Berwyn Court
Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

6 June 2023

Ms Z G Malindisa
211 Boswell Avenue
Mondeor
Johannesburg
2091

Dear Ms Malindisa

Student nurses and educators' experiences of clinical teaching and learning during COVID-19 pandemic in selected campuses of Gauteng College of Nursing
Ethics Clearance Number: IREC 309/22

The DUT-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 DUT-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 DUT-IREC according to the DUT-IREC SOP's.

Please note that any deviations from the approved proposal require the approval of the DUT-IREC as outlined in the DUT-IREC SOP's.

It is compulsory for a student or researcher to apply for recertification on an annual basis. The failure to do so will result in withdrawal of ethics clearance. It is the responsibility of the researcher and the supervisor to apply for recertification.

Please note that you are required to submit a Notification of Completion of Study form together with an abstract to the DUT-IREC office on completion of your study.

Yours Sincerely

Prof J K Adam
Chairperson: DUT-IREC

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fairness · professionalism · commitment · compassion · excellence

Appendix G: Editing Certificate

04 October 2024

DECLARATION OF PROFESSIONAL EDIT

I declare that I have edited and proofread a Master of Health Sciences in Nursing dissertation entitled: **STUDENT NURSES AND EDUCATORS' EXPERIENCES OF CLINICAL TEACHING AND LEARNING DURING COVID-19 PANDEMIC IN SELECTED CAMPUSES OF GAUTENG COLLEGE OF NURSING by Zandile Goodness Malindisa.**

My involvement was restricted to language editing: contextual spelling, grammar, punctuation, unclear antecedent, wordiness, vocabulary enhancement, sentence structure and style, proofreading, sentence completeness, sentence rewriting, consistency, referencing style, editing of headings and captions. I did not do structural re-writing of the content. Kindly note that the manuscript was not formatted as per agreement with the client.

No responsibility is taken for any occurrences of plagiarism, which may not be obvious to the editor. The client is responsible for ensuring that all sources are listed in the reference list/bibliography. The editor is not accountable for any changes made to this document by the author or any other party subsequent to my edit. The client is responsible for the quality and accuracy of the final submission/publication.

Sincerely,

PhD Communication [Candidate]

MA Communication Science [Cum Laude]

BA Honours Communication Science

BA Humanities

Pholile Zengele
Associate Member

Membership number: ZEN001
Membership year: March 2024 to February 2025

076 103 4817
info@zenedit.co.za

www.editors.org.za