



**Experiences of undergraduate nursing students during their experiential
learning in Boland Overberg healthcare facilities**

by

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DECLARATION

I, Fundiswa Pearl Fadana, hereby declare that the contents of this thesis titled 'Experiences of undergraduate nursing students during their experiential learning in Boland Overberg healthcare facilities' represent my own unaided work and that the thesis has not previously been submitted for academic examination towards any qualification. All the resources that I have used have been indicated and acknowledged by means of complete references.

A handwritten signature in black ink, appearing to read 'F. Fadana', written in a cursive style.

Signed

Date 30 October 2019

Abstract

Nursing is a practice-based discipline, which makes experiential learning an important part of nursing education. The main purpose of experiential learning is to give students an opportunity to transfer theory into practice. It also equips the undergraduate student nurse with the skills and knowledge needed to provide high-quality care based on patients'/clients' needs and to produce competent and confident decision makers who are ready to accept personal and professional accountability. Experiential learning is accomplished by placing the undergraduate nursing students within a clinical learning environment. The success of the nursing programmes depends on appropriate clinical experience. The purpose of this research was to explore and describe the experiences of undergraduate nursing students during experiential learning in healthcare facilities at the Boland Overberg Campus in the Western Cape. A qualitative, exploratory, descriptive design was applied. Data collection was done using focus-group interviews to ascertain the undergraduate student nurses' experiences during clinical practice in healthcare facilities in the Boland Overberg area. Thirty-eight undergraduate nursing students from Boland Campus were selected, using purposive sampling. The ethical principles relevant to this study were observed. Colaizzi's method of coding and thematic content analysis were used to interpret the data. The results of this study revealed that students were not satisfied with the clinical learning environment, which was not conducive to their learning. The students were not supported and supervised by the registered nurses in the facilities. This resulted in a lack of theory and practice integration. Furthermore, the results revealed that the students faced challenges during clinical practice. One of the most challenging factors was negative staff attitudes. It was evident that even though being in clinical settings was sometimes very challenging and frightening, there were also joyful moments. Seeing the patient recover gave students satisfaction and a reason to return the next day.

KEYWORDS: Experiential learning; undergraduate nursing students; clinical environment; competence, clinical practice.

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Dedication

I dedicate this study to my Lord and saviour Jesus Christ, who strengthened me throughout this journey. It was not easy, but through His help and guidance I managed to reach this point. To my husband, Mxolisi Fadana who was there for me during stressful times. To my children Yomi and Khanya, thank you Madlomo for your support and encouragement.

LIST OF ABBREVIATIONS

CPUT	Cape Peninsula University of Technology
NEIs	Nursing Education Institutions
OSCE	Objective Structured Clinical Examination
SANC	South African Nursing Council
WCCN	Western Cape College of Nursing

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CHAPTER 1

1.1 Introduction

Nursing is a practice-based discipline. Hence, experiential learning is regarded as an important component of nursing education. Through experiential learning, students acquire experiences that assist them to acquire the necessary skills and knowledge to become capable of supporting human lives through practice of nursing (Mueller, Naragon and Smith, 2016:3). The above authors stated that if essential learning opportunities are missed for the students and they are exposed to negative experiences, these nursing students may not be able to grow in learning or they will remain incompetent in the field. This may lead to patient safety issues.

In South Africa, nursing training is guided by the statutory body, the South African Nursing Council (South Africa, 2005). The undergraduate training is regulated by Regulation No. 425 of 22 February 1985 (as amended in the *Nursing Act No. 33 of 2005*). The South African Nursing Council (SANC) also prescribes the number of experiential training hours that student nurses must complete for each year (South Africa, 2005:30).

Boland Overberg Campus is the rural satellite campus of the Western Cape College of Nursing (WCCN) and is situated in Worcester. This campus offers a four-year comprehensive course which leads to registration as a general, psychiatric and community nurse, as well as a midwife.

During training, undergraduate nurses spend time in the clinical areas as well as in the classroom. In the researcher's own experience, as an educator at a nursing college, when the undergraduate nurses return from their placement areas, they usually reflect on their experiences while they were doing clinical practice. Students mostly complain about factors at healthcare facilities that are not conducive to learning. These factors include the shortage of ward staff, attitudes of ward staff, and the lack of challenging learning opportunities. According to these students, these factors affect their learning negatively. Undergraduate nurses complained about the environment not being conducive to learning. A conducive learning environment depends on the availability of placement support systems. Such support systems are the relationship between the college staff, student nurses and ward staff (Arora, 2015:22). Not all clinical placement areas are conducive to student learning (Papastavrou et al., 2016:3). Ali et al. (2015:1) state that qualified staff should provide such an environment by acting as mentors, supervisors, and assessors. As a nurse educator, the researcher visited the students at their placement areas. This was when the researcher received complaints from ward staff about student nurses being clinically incompetent. The discrepancies between the comments of student nurses and

the complaints of the clinical staff, motivated the researcher to conduct the study. Through this project, the researcher hoped to get a better understanding of student nurses' experiences while doing experiential learning in healthcare facilities in the Boland Overberg area.

1.2 Background to the study

In South Africa, nursing education comprises of various programmes. These programmes are offered at universities, colleges, and nursing schools. In order for these training institutions to continue with the training of students, they must be accredited by the SANC. The SANC is the statutory body for nurses and it governs all the nursing education institutions (NEIs), in both colleges and universities (South Africa, 2005:7). Nursing education programmes support development of the knowledge, skills and attitudes required to be fit to practice as a qualified nurse (Jack et al, 2017:4707).

The R425 programme is one of the basic programmes offered over a period of four years. This programme is only offered on a full-time basis. During their training, these nursing students are prepared to be competent and safe practitioners. On completion of the course, the graduates are expected to be analytic, creative and have critical thinking skills (South Africa, 2005:2).

Nursing education comprises theory and clinical practice. Many researchers agree that experiential learning is an important component of nursing education (Mwai, 2014:5; Tiwaken et al., 2015:66). Nursing education depends on the successful integration of theory and practice (Ali et al., 2015:1). Student nurses first spend time in the classroom, learning nursing theories and diverse subject matter. Theoretical learning takes place before students enter the healthcare facilities. This helps the student nurses to apply the theory they have learned in the classroom to practice when they are placed in healthcare facilities. While the student nurses are in class, they are taught basic theory and are given many opportunities to observe and practise nursing skills in the simulation laboratory, as well as role-play and demonstrations in the classroom. SANC requires that students following the R425 programme spend a total of 4000 hours doing clinical practice (SANC, 1985:21). For students to fulfil this requirement, they are placed in healthcare facilities where they do experiential learning, and where they are expected to apply theory to practice. According to Vember (2017:125), the students are not allowed to progress if they do not fulfil their practical requirements. The directive of nursing education institutions is to prepare and produce nurses that are capable of rendering nursing care that is appropriate for the health needs of society (Mukumbang & Adejumo, 2014:1).

During placement, students are expected to develop knowledge and skills such as communication skills, competence and confidence (Moonaghi et al., 2015:1). On completion of the course, students are expected to have adequate knowledge to be able to transform competencies into effective performances. In the placement areas, student nurses work closely with clinical mentors and ward staff (Emanuel & Pryce-Miller, 2013:18; Bjørk, et al., 2014:2959). Mentors and qualified staff should provide an environment that is conducive to student learning. The purpose of experiential learning is to equip the undergraduate nursing students with the skills and knowledge needed to provide high-quality care based on the patient's needs and to produce a clinically competent nurse. Registered nurses are expected to share their skills, knowledge and experiences to support the student's learning and to help students develop their professional competence and confidence (Royal College of Nursing, 2017:6). Experiential learning involves any learning that supports students in applying knowledge and conceptual understanding to real-world problems and engages them in critical thinking, problem solving and decision making in different contexts that are personally relevant to them. According to Dafogianni et al. (2015:674), experiential learning in the clinical environment also contributes to shaping the attitudes and behaviours of the undergraduate student nurse. This is the time the undergraduate student learns clinical practice and how to become a professional.

1.3 Problem statement

Nursing education comprises both theory and clinical practice. The SANC requires R425 students to spend a total of 4000 hours doing clinical practice (SANC, 1985:21). In order to meet this requirement, undergraduate students are placed in healthcare facilities, where they are expected to do experiential learning. During this period, these students are expected to correlate theory with practice. As a nurse educator, the researcher found that the students were not satisfied with their clinical learning during placement and complained about the environment not being conducive to learning. This was observed over eight years (8) of working with these students and doing accompaniment. These negative complaints were evident in their poor performance during the objective structured clinical examination (OSCE). During the OSCEs, students are assessed on their clinical skill competencies. It was during these OSCEs that the researcher noticed that students were neither confident nor clinically skilled and competent. Students performed poorly. Even though Student performance was poor, failure rate was not high due to the tool that was used during the OSCEs. The students memorised the tool and during the OSCEs, they just regurgitate, without insight. In the wards, the ward staff complained of students' clinical incompetence,

especially during community service. These are the issues that prompted an interest in formally investigating the experiences of undergraduate nurses during experiential learning in healthcare facilities.

1.4 Research question

What are the experiences of undergraduate nursing students during their experiential learning in public healthcare facilities in the Boland Overberg area of the Western Cape?

1.5 Purpose of the study

The purpose of this study was to explore and describe the experiences of undergraduate student nurses during clinical practice in healthcare facilities.

1.6 Research objectives

- To explore and describe the experiences of Boland Overberg nursing students during experiential learning.
- To explore and understand the student nurses' feelings during experiential learning in healthcare facilities.
- To explore the challenges encountered by the undergraduate student nurses during experiential learning.

1.7 Clarification of basic terms and concepts

Experiential learning

"Experiential learning exists when a personally responsible participant cognitively, affectively, and behaviourally processes knowledge, skills, and attitudes in a learning situation characterized by a high level of active involvement" (Hoover & Whitehead, 1976:25 and Isakovic, 2015:114). Experiential learning is when learners form new knowledge that captures their social reality by trying out theory in practice, experiential learning involves learning from experience. (Smith et al., 2008:3; Caulfield & Woods, 2013:32; Austin & Rust, 2015:143).

Clinical staff

Clinical staff refers to registered nurses who are independent practitioners authorised to practise and registered with the SANC.

Competence

Competence is the ability to effectively integrate cognitive, affective and psychomotor skills when delivering nursing care.

Student nurse

A student nurse is an individual enrolled in a school of nursing for a formal educational nursing programme that leads to a degree in nursing.

Clinical learning environment

Clinical learning environment is a place in any practice a setting which includes wards, community health care centres and old age homes where student nurses learn (Quinn, 2000:413; Flott & Linden, 2015:502).

1.8 Theoretical framework

This study was guided by Imogen King's Goal Attainment Theory. This theory was developed by King in 1960 (Wayne, 2014; McQueen et al., 2017:223). The aim of this theory is the attainment of certain life goals. Goal Attainment Theory is based on three concepts: personal, interpersonal and social systems.

Goal Attainment Theory was applied to this study, because as an individual (personal aspect), the student nurse must be actively involved in learning in order to grow and reach his/her goal. In the work environment, the student nurse is not alone but among ward staff (interpersonal) with whom they interact. It is hoped that they will learn and experience professional cultures and clinical competencies under the supervision of the ward staff. They also interact with other groups of students (social aspect) who share the same interests.

During this interaction, students and ward staff communicate, reach agreement and set goals, which in this case should assist students in becoming safe and competent nursing practitioners. King's theory focuses on interpersonal systems and the interactions, communication, and transactions between two parties (George, 2014:260). In this study, the parties were the training institution staff, students and nurse clinicians where the students were placed (Department of Health staff). The parties involved came together, communicated and reached agreement. They set goals together. The students, together with nurse clinicians from the placement area and academic staff from the training institution, plan how to take undergraduate students to clinical competence and groom or shape them for the nursing profession (King, 1981:144; George, 2014:257; Wayne, 2014).

All the parties involved should work together to achieve these goals. According to George (2014:260), each of the members of the parties involved has a purpose. They perceive, judge, act, and react to one another. The main purpose of this interaction is to help students to become competent and to enable them to produce a high level of quality care.

Interaction, communication, and transactions occur in the environment of the people involved. The placement area, which is a healthcare facility, is the environment where interaction, communication, and transactions occur between facilitator/mentor and student. In social systems, the undergraduate nurses interact with groups of people within a society sharing common goals, cultures, interests, and values. Social systems also influence the quality of care. During placement, an undergraduate nursing student interacts with all staff members in the ward, as well as with patients and other healthcare professionals constituting the health team. It is here where the student learns to understand various cultural practices, how to make decisions, and how to practise power effectively. These aspects should all occur within an ethical and professional framework. It is during this time that registered nurses in the ward get a chance to mentor undergraduate students. In the ward environment, all role-players (ward staff and student nurses) are usually strangers, who come together to help and to be helped in order to reach a common goal (George, 2014:260).

1.9 Research methodology

1.9.1 Research design

Grove et al. (2015:511) define a research design as a blueprint for the study aimed at controlling the factors that may influence the validity of the study. Polit and Beck (2017:56) concur. A research design helps the researcher to obtain answers to research questions (LoBiondo Wood & Haber 2014:8; Polit & Beck, 2017:56). For this study, a qualitative descriptive, explorative and contextual design was employed. This method assisted the researcher to describe the experiences of the Boland Overberg Campus nursing students during experiential learning and it allowed the researcher to obtain an in-depth understanding of the experiences of nursing students during their experiential learning (Toles & Barroso, 2014:96). Grove et al. (2015:509) describe qualitative research as a systematic, subjective approach used to describe life experiences and give them significance.

The research design is discussed in detail in Chapter 3.

1.9.2 Population

Population refers to all the individuals about whom the research problem is concerned (Polit & Beck, 2017:249). For this study, the population comprised all the R425 nursing students (2nd – 4th years) on the Boland Overberg Campus.

1.9.3 Setting

This study was conducted at the Boland Overberg Campus which is a satellite campus of a university in the Western Cape. This campus is located in Worcester in the Cape Winelands district in a semi-rural area of the Western Cape, South Africa. Most of the nursing students come from this area, while a few are from the Eastern Cape. Most of the people in this area speak Afrikaans and in most clinical placement areas, Afrikaans is the main language of communication. Undergraduate student nurses from this campus are placed in accredited hospitals, community healthcare centres, day-care clinics and other healthcare facilities in this area.

1.9.4 Sample

Purposive sampling was used for this project and 38 participants were selected from second-, third- and fourth-year levels. The first years were not included, as they were not yet exposed (at the time of data collection) to experiential learning. The researcher chose purposive sampling because it involved conscious selection of subjects by the researcher (Grove et al., 2015:509). These students were mostly out in the clinical setting doing experiential learning in various healthcare facilities. This assisted the researcher in collecting rich data from the participants. The students recruited were well informed about the research study.

1.9.5 Inclusion criteria

All second-, third- and fourth-year students enrolled for the R425 programme (the course leading to registration as a nurse (general, psychiatry, community) and midwife at Boland Campus were included. They were all 18 years and older. Participants comprised both male and female students.

1.9.6 Exclusion criteria

All R425 nursing students under 18 years of age were excluded.

All R425 undergraduate students in their first year were excluded since at the time of data collection they had not yet been exposed to clinical practice.

1.10 Method of data collection

The researcher used focus-group interviews to collect data. Open-ended questions were used for the students to describe their experiences while practising in healthcare facilities. All interviews were audiotaped. Chapter 3 describes the data-collection process in detail.

1.11 Ethical considerations

Research ethics is the study of appropriate ethical standards for research involving humans (and animals). It includes the establishment of appropriate governance for such research (Polit & Beck, 2017:727). According to Polit and Beck (2017:137) and Grove et al. (2015:98), the foundation for research ethics is formed by the Belmont Report, Nuremberg Code, and Declaration of Helsinki. The Declaration of Helsinki was adopted in 1964 and last amended in 2013. This promotes the protection of human subjects from harm (Grove et al., 2015:96). The Belmont Report joined three broad principles on which standards of ethical conduct are based: beneficence, respect for human dignity, and justice (Polit and Beck, 2017:139).

The researcher started collecting data as soon as approval from the Ethics Committee of the Cape Peninsula University of Technology (CPUT), was granted (refer to Appendix F). Ethical principles of autonomy, informed consent, beneficence and non-beneficence, justice, respect for persons and confidentiality, were upheld throughout this study. The detailed information regarding ethical consideration is discussed in Chapter 3.

1.12 The layout of the study is as follows

Chapter 1

In this chapter, the introduction and motivation, the background to the research problem, research question, and aim and objectives of the study were discussed. Furthermore, the research design and method, and ethical considerations, were discussed.

Chapter 2

This chapter included a literature review of pertinent literature, addressing the issues regarding experiences of undergraduate nursing students during their experiential learning globally, nationally and provincially.

Chapter 3

This chapter outlined the methodology of this study and described the research design, settings, population and sampling, recruitment of participants, data collection and detailed ethical considerations.

Chapter 4

This chapter discussed the details of data management and data analysis methods used in this study. This chapter also discussed in detail the measures taken to ensure the trustworthiness of this study.

Chapter 5

Discussions of the findings were presented, including the literature that related to the themes that emerged from data analysis.

Chapter 6

In this chapter, conclusions of the study were discussed, and limitations and recommendations based on the study findings were presented.

1.13 Summary

In this chapter, the researcher described the background to this study, as well as the objectives of the study. A brief introduction to the research methodology as applied in this study was presented. The next chapter (Chapter 2) will present a literature review providing an in-depth understanding of experiences of undergraduate student nurses during experiential learning.

CHAPTER 2

Literature Review

2.1 Introduction

According to Fulton & Krainovich-Miller (2014:50), a literature review serves as the building block and basis of a study. A thorough literature review forms a foundation whereon to base new evidence and is usually done before data are collected (Polit & Beck, 2017:54). The purpose of a literature review is to convey to the reader what is currently known regarding the topic of interest and to obtain a general background and understanding of what is already known about the specific problem (Grove et al., 2013: 98; Polit & Beck, 2017:87). In this study, a literature review was done before data collection, since a literature review serves as the building block and foundation for the study (Fulton & Krainovich-Miller, 2014:50). However, Grove et al. (2015:164) argue that a literature review should be done after data collection, to avoid biases about the topic under consideration. The literature reviewed focused on major factors related to undergraduate student nurses' experiences during experiential learning while in placement areas. Many researchers agree that experiential learning is an important component of nursing education (Mwai, 2014:5; Tiwaken et al., 2015:66), hence the experiences of undergraduate nurses during clinical learning are very important in the teaching and learning of nurses (Kaphagawani & Useh, 2013:185; Welby-Solomon, 2015:ii; Mthimunye, & Daniels, 2019:2; Rajeswaran, 2016:1).

Despite all studies done on the clinical practice of an undergraduate student nurse, experiential learning in health care facilities 'in real situations', is still a problem. The literature reviewed revealed many factors involved in the success of learning in the clinical environment. Experiential learning of the student nurse occurs in a clinical environment; therefore, the clinical learning environment will also be discussed. The researcher conducted a literature search using Google Scholar, EBSCO host, Science Direct, journals, books, and studies from other researchers. Certain keywords and phrases, such as experiential learning of an undergraduate nursing student, experiences of student nurses during clinical practice, clinical practice environment, and clinical setting were used to search for relevant literature. The review was organised into themes as Grove et al. (2015: 183) suggest, and the main concepts of the study were framed according to the following themes: experiential learning, clinical environment, staff shortage, and theory–practice gap.

2.2 Nursing education programmes

Nursing education and training programmes for the training of student nurses to become professional nurses, differ from country to country. In Malawi the students undergo a training of four (4yrs) after which they are awarded a Bachelor of Science degree and will be registered as professional nurses (Kaphagawani, 2015:4). According to Nyelisani (2016:1), in the United States of America, nursing students follow a three(3) year diploma programme which is offered at hospital, a three – year associate degree which is offered at a community college and a four (4)- year Bachelor's Degree offered at universities. In the United Kingdom nursing and midwifery programmes are separate professions and the training for these are offered in separate nursing education programmes (Nyelisani (2016:1). According to Mamaghani et al. (2018:217), nursing students undergo a training of four (4) years. The first three (3) years of their training is theory, practical and clinical course work. During these years, students usually spend two to three shifts per week in clinical placement areas. In South Africa nursing education programmes are being reviewed. South African Nursing Council (SANC), the regulator of nurses in South Africa, sets standards for the education and training of nurses including clinical learning programmes and approved such programmes that meet the requirements of the Nursing Act, 33 of 2005.

In South Africa nurses follow a four (4) year diploma programme which is done in colleges and lead to registration as a professional nurse. A four (4) year programme, leading to a Bachelor's Degree is offered by the universities and also lead to registration as professional nurses. In South the curriculum is provided by the regulatory body which is SANC. However, universities also have a responsibility to align their programmes to the Higher Education Qualifications Framework. In South Africa the competency based model was adopted for the four year undergraduate nursing programmes, with a focus on primary health care. The focus on this model is on developing competent learners through the acquisition of specified competencies (Magerman 2015:4). According to Bimray, Le Roux and Fakude (2013:118), the clinical competencies that covers all the four (4) year's levels are communication, assessment, and care. The above authors state that these clinical competencies facilitate the integration of theory, practical and attitudes which is needed to work effectively in the clinical environment. The competency-based education is outcomes-based instruction and it describes the student nurses' ability to apply knowledge, skills and behaviours encountered in everyday situations (Magerman, 2015:4). At the college, teaching and learning is structured according to the competency-based curriculum. In order for the student to be regarded as competent, she/he must demonstrate and

understanding of what she/he is doing and why they are doing it, an ability to perform a set of procedures and the ability to integrate theory and practice. Hence the importance of experiential learning, which offers multiple opportunities for students to practice and to integrate theory into practice.

2.3 Experiential learning

Experiential learning is a transformative learning whereby the person experiences a deep, structured shift in the basic premises of thought, feelings, and actions (Potgieter, 2012:5; Strange & Gibson, 2017:86; Wurdinger, & Allison, 2017:1). Fenwick (2001:16) and Van der Wath & Du Toit (2015:2), describe experiential learning as a philosophy and teaching method that focuses on the relationship between students, their concrete experience and their reflective processes about the experience. During experiential learning nursing students are given opportunities to apply the nursing theory and science of nursing. It is during this time that they get a chance to practice nursing skills that are necessary to practice as a professional nurse after completion (Mueller et al., 2016:3).

Experiential learning is learning by doing, rather than listening to other people or reading about it (Hughes & Quinn, 2013:28; Austin, & Rust, 2015:143). It prepares student nurses with the ability of 'doing' as well as 'knowing' the clinical principles in nursing practice. It provides students with opportunities for active self-learning, self-development and the ability to apply their knowledge from a theoretical context situation to an emergency and general public healthcare situation (Uchechukwu, 2014:16). Active involvement of the student is one of the key characteristics of experiential learning (Hughes & Quinn, 2013:28).

According to Garnett (2016:55), experiential learning is increasingly accepted as fundamental to professional development and work-based learning. In a study done by Wurdinger & Allison (2017:1), students considered experiential learning enjoyable, compared to didactic approaches. These students believed that experiential learning leads to deeper learning, compared to a theoretical approach. During experiential learning, the students undergo multiple trials and errors, which allow students to learn from their mistakes (Wurdinger & Allison (2017:17).

In professional education, especially in the health fields such as medicine, nursing, pharmacy, and other health programmes, experiential educational programmes continue to account for a significant part of the curriculum (DiFrancesco, 2012:7; Shubnum et al., 2018:58). In most instances the quality of experiential learning reflects the quality of the curriculum structures (Shubnum et al., 2018:58). For many decades, experiential learning

has been viewed as an important component of nursing education (Nabolsi et al., 2012:5849; Mwai, 2014:4; Baraz et al., 2015:1; Karabulut et al., 2015:e9). Quality of nursing education and quality of nursing as a profession depend on the quality of experiential learning of student nurses (D'Souza, 2013:25; Kaphagawani, 2015: xxi). Experiential learning prepares nursing students to enter the workforce as competent and independent practitioners (Grace & O'Neil, 2014:291; Msiska et al., 2014:35; Heidari & Norouzadeh, 2015:39). Experiential learning of student nurses takes place in healthcare facilities. During their training, student nurses are placed in clinical areas where they are expected to observe role models, and practise and develop their clinical skills, as well as their problem-solving and decision-making abilities (Xaba, 2015:iii; Kaphagawani, 2015:1). It is during this time, that students get the opportunity to correlate theory with practice (Kaphagawani & Useh, 2013:181; Kaphagawani, 2015:1).

Studies done in Iran revealed that the experiential learning of a student nurse is very complicated and demanding owing to the nature of the environment where this takes place and is unpredictable and beyond the control of faculty members (D'Souza et al., 2013:26; Baraz et al., 2015:1; Dinmohammadi et al., 2016:31).

Literature identified a few common factors experienced by undergraduate nursing students during clinical practice. These factors were either related to the unfriendly clinical environment, shortage of staff, role modelling and theory–practice gap (Dale et al., 2013:3; Mwai, 2014:14; Zenani, 2016: vi; Arkan et al., 2018:129). These factors can affect the learning of the undergraduate positively as well as negatively (Kaphagawani & Useh, 2013: 185; Abouelfetoh & Mumtin, 2015:497; Tiwaken et al., 2015:72).

2.4 Global context

Globally nursing education is facing difficulties which make the training of undergraduate nursing students challenging. These challenging's were identified in Iran from the traditional clinical training, crowded hospitals shortage of staff large numbers of students in the wards (Kalyani et al., 2019:2). According to the above authors student nurses in Iran are at risk of being exposed to bad learning experiences. In Malawi Kaphagawani and Useh (2015:224) reported large numbers in clinical placement areas which are the challenge to learning achievements of student nurses.

2.4.1 Clinical learning environment

Experiential learning occurs in the clinical environment. This can be in a simulation laboratory, but it needs to be practised and developed in a clinical setting in hospitals, clinics, and old age homes where real-life situations take place (Abouelfetoh & Mumtin, 2014:491; Sundler et al., 2014:661). The clinical learning environment is an interactive network of forces within the clinical setting that influences the students' clinical learning outcomes (Baraz et al., 2015:1; Watson-Miller, 2015:28). The clinical learning environment is situated in any practice setting. It includes wards, community health care centres, and old age homes where student nurses learn (Hughes & Quinn, 2013:356; Sundler et al., 2014:661; Bigdeli et al., 2015:111). The clinical learning environment is where students interact with patients/clients and their families to acquire clinical skills and is a place where they get a chance to work with other healthcare staff to acquire teamwork skills and professionalism.

According to Hughes and Quinn (2013:356); Wurdinger and Allison (2017:1), the clinical learning gained in the real world of clinical nursing is more relevant than that acquired in the classroom or the simulation laboratory. The literature reviewed revealed that the learning environment plays a vital role in the student's learning, and can influence it desirably or harmfully (Mwai, 2014:6; Jamshidi 2016:1). A good quality environment is determined above all by a good atmosphere in the ward. This is facilitated by open communication and co-operation between the university and staff (Motsilanyane, 2015:76). There are many factors that influence the experiences of undergraduate nurses during placement (Hughes and Quinn 2013:357; Lawal et al, 2016:32). These factors include ward culture, the business of the unit and exposure to learning opportunities. The clinical learning environment in the healthcare setting should include all the following aspects essential for student nurses in the clinical placement areas. This includes equipment, ward staff, patients, clinical mentors, and nurse educators. The clinical learning environment includes everything that surrounds the nursing students, including the clinical setting, staff and patients (Ali et al., 2015:1). Abouelfetoh and Mumtin (2014:491) view the clinical environment as double structured. It consists of the learning environment that includes the ward atmosphere, culture and complexities of care. Other contributory factors are the supervisory relationships with students, as well as with clinical and nursing college staff.

Experiential learning is influenced by the environment where it takes place (Jamshidi et al., 2016:1; Lawal et al., 2016:36). The learning environment should be conducive to be effective, but unfortunately, students do not believe that all clinical learning environments

are conducive to learning (Serçekuş & Başkale, 2016:134; Shivers et al., 2017:58). A positive clinical environment where students are welcomed to be part of the team and where ward nurses embrace the opportunity to mentor student nurses is more conducive to learning (Pama, 2017:48). According to Ali et al. (2015:1), it is the responsibility of clinical staff to create and develop a conducive learning environment for all students. The clinical learning environment should be monitored continuously to ensure that it provides support to students and takes care of changes. A conducive clinical environment is an environment where the staff is friendly with good morals and attitudes and an environment where the staff is willing to teach and guide students to provide quality patient care (Papastavrou et al., 2010:176; Mcconnell & Mckay, 2018:38). It is the responsibility of clinical and academic staff, as well as students, to create a conducive learning environment (Bvumbwe et al., 2015:927).

2.4.2 Staff shortage

The shortage of nursing staff is a global issue and has a negative impact on the experiential learning of student nurses (Msiska, 2012:128; Haddad & Toney-Butler, 2019; Daniel & Smith, 2018:1). Motsilanyane (2015:82) revealed that hospital personnel take time off, leaving students alone with a heavy workload. Ward staff perceive the presence of students in the ward as time for nurses to be relieved. According to Rikhotso et al. (2014:e2), students could not have a nurse–patient relationship owing to a heavy workload. Shortage of hospital staff is an issue that leads to problems such as students’ “lacking direction in their learning” and feeling useless and seeing themselves as a burden to other staff. In the study done by Rikhotso et al. (2014:e2), hospital staff view students as a burden and an increase in the workload. Owing to staff shortages, students do not get time to reflect on their experiences. They, for example, will not get an opportunity to give medication, even if that is a learning objective. Instead, they will be allocated for observations (Msiska, 2012:194; Msiska, et al., 2014:38).

2.4.3 Role modelling

During placement, it is important for students to be exposed to positive role models who are viewed as having great influence on learning of student nurse in clinical area (Jack et al., 2017:4712). According to de Swardt et al. (2017:2); Jack et al. (2017:4712), nursing students are exposed to unprofessional practices through poor role models, for example, witnessing poor practice in clinical settings. Nurses complained of ward staff that behaved inappropriately (Hakimzadeh et al., 2013:182; Grissinger, 2017:74). According to Jack et

al. (2017:4712), all staff members are seen as role models by students, hence students expect to be treated well by all qualified staff, who they regard as their role models.

2.4.4 Theory–practice gap

The gap between theory and practice is a common problem of programmes presented in nursing faculties and leads to failure in the clinical area (Hakimzadeh et al., 2013:182; Hussein & Osuji, 2017:23). Most researchers have established a gap between theory and practice, which hinders students' experiential learning (Safazadeh et al., 2018:105; Xaba, 2015:13). Kaphagawani and Useh (2013:182); Hussein and Osuji (2017:20), describe the theory–practice gap as the disparity between what has been taught in the classroom setting and what is practised in the clinical environment. According to Rajeswaran (2016:471), the reason for the clinical placement of students is to integrate the theory provided by the educational institution with the realities of nursing practice. The conflict between the theory taught and clinical practice results in students' being confused and frustrated, and this leads to considerable stress and anxiety. Stress and anxiety make the learning ineffective; therefore, students are unprepared for work as registered professional nurses (Yousefy et al., 2015:1298; Serçekuş & Başkale, 2016:136).

2.5 The South African context

Despite an extensive search, very little research was found on this topic in the South African context. The quality of nurse education depends largely on the quality of the clinical experience that student nurses receive in the clinical environment (Khoza, 2015:103). A few studies done in South Africa revealed that nursing students experience many challenges during their clinical practice. While the students are in clinical practice, they are faced with problems such as shortages of staff which affect student training negatively. In the study done by Mothiba et al. (2012:195); Malwela et al. (2016:2) in Limpopo, South Africa, one of the challenging issues was the integration of theory and practice. Hussein & Osuji (2017:20); Mabuda et al. (2008:23) concur with Malwela et al. (2016) that students are taught one thing at nursing college, but on the wards, where they face the realities of nursing practice, they experience something different from what they were taught. Students felt that what they learned at college was too ideological and not functional in real patient situations. Role modelling was also found to be an issue that needs to be considered. According to Cunze (2016:65), role models should challenge themselves, and that will encourage students to look up to them. Punctuality, discipline, respect, and appreciation would uplift the image of the profession and would not only benefit students, but also

improve perceptions of nursing held by the public at large. Professional nurses should be aware of their importance as role models for student nurses. It is imperative for students to develop and apply the learnt professional qualities in practice (Cunze, 2016:64).

2.6 Summary

The literature reviewed revealed that the clinical learning environment can influence the learning environment of the student nurse positively or negatively. In an environment with mutual respect, support, teamwork and a sense of belonging, students are motivated to learn. Students develop confidence and independent learning skills when they are respected, trusted and treated as part of the team. Most researchers in South Africa and in other countries established a gap exists between theory and clinical practice (Dadgaran et al., 2012:1713; Kaphagawani, 2015:152; Mamaghani et al., 2018:220). This also militates against student learning. According to Cunze (2016:65), role models should challenge themselves, which in turn will encourage students to look up to them.

From literature reviewed the researcher identified the need to conduct the present study. In South Africa there are a few studies that were done pertaining to the experiences of undergraduate nursing students during experiential learning. Through this project, the researcher hoped to get a better understanding of student nurses' experiences while doing experiential learning in healthcare facilities in the Boland Overberg area. Hence, this study explored and described the experiences of undergraduate student nurses during clinical practice in healthcare facilities. The knowledge and understanding of how these undergraduate students experience things would help the nurse educators as well as the clinical staff in clinical settings, to develop appropriate strategies to facilitate the progress of clinical competence of student nurses and to improve the quality of nursing education. In the next chapter, Chapter 3, the methodology and design of the research are discussed.

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CHAPTER 3

Research Methodology

3.1 Introduction

This chapter focuses on the research methodology. Research methodology describes how a researcher conducted the study and which techniques were used, as well as what the researcher did to answer the research question (Grove et al., 2015:82; Brink et al., 2018:187). Research methods are techniques that are used in research to gather evidence and to give guidance of how to conduct research (Grove et al., 2015:25). Research methodology encompasses research design, sample collection, data-collection methods, data processing and data analysis (Grove et al., 2015:82; Brink et al., 2018:187). In this chapter, the researcher provided a detailed account of how the researcher approached answering the research question in a qualitative paradigm.

Gray et al. (2017: 690), define research as a diligent, systematic inquiry or investigation to validate and refine existing knowledge and generate new knowledge. The researcher worked within a qualitative paradigm to generate new knowledge.

3.2 Research design

The research design is a blueprint for the study aimed at controlling the factors that may influence the validity and trustworthiness of the study (Grove et al., 2015:502). The best research design is the one that is most appropriate to the research problem and purpose statement (Brink et al., 2018:112). Polit and Beck (2017:56) describe research design as the overall plan to address a research question, including the specifications to increase the study's integrity. It also constitutes the backbone of the study.

The research design helps the researcher obtain answers to research questions and to gain insight through discovering new meanings (LoBiondo Wood & Haber 2014:8; Polit & Beck, 2017:56). For this study, a qualitative explorative, descriptive, contextual design was employed. This design was found appropriate in answering the research question: "What are the experiences of undergraduate nursing students during their experiential learning in public healthcare facilities in the Boland Overberg area of the Western Cape?"

3.2.1 Qualitative research

According to Grove et al. (2015:62), qualitative research is a systematic, subjective approach used to describe life experiences and give them significance. This method was chosen because it elicits rich and in-depth findings that provide a unique appreciation of the reality of different experiences. The researcher also chose a qualitative method, since

the focus was on practices, behaviour, and attitudes which are part of the lived experiences of student nurses (LiBiondo Wood & Haber 2014:8). Qualitative research is especially effective in obtaining culturally specific information about the values, opinions, behaviours, and social contexts of populations (Grove et al., 2013:24; Gray et al., 2017:25). Qualitative methods study human experiences from the perspective of the participants, in the context in which the phenomenon takes place (LiBiondo-Wood & Haber, 2014:8; Gray et al., 2017:62; Polit & Beck, 2017:270). The current research seeks to explore the experiences of student nurses during experiential learning in healthcare facilities. The researcher chose qualitative methods because they allowed for more freedom and adaptation of interaction between the researcher and the participants. Qualitative methods ask mostly 'open-ended' questions that are not necessarily worded in the same way with each participant. With open-ended questions, participants are free to respond in their own words, and these responses tend to be more complex than simply 'yes' or 'no' (Hashemneszhad, 2015:56). The use of open-ended questions and probing gives study participants the opportunity to respond in their own words, rather than forcing them to choose from fixed responses. The researcher used open-ended questions because they have the ability to evoke responses not expected or predicted by the interviewer (Polit & Beck, 2017:270). These types of questions generated responses that were rich and exploratory. This method assisted the investigator to explore and describe the experiences of the Boland Overberg Campus nursing students during experiential learning and it allowed for an in-depth understanding regarding the experiences of nursing students during their experiential learning (Toles & Barroso, 2014:96).

The purpose of this study was to explore and describe the experiences of undergraduate student nurses during clinical practice in healthcare facilities. The types of qualitative research designs applied in this study are now discussed.

3.2.2 Descriptive research

A descriptive design helped to gather more information about the experiences of undergraduate nurses during their clinical learning in healthcare facilities and to identify challenges these students faced during their clinical practice in placement areas (Grove et al., 2013: 215; Brink et al., 2018:96). According to Brown (2014) and Kerlinger and Lee (2000), cited in Grove et al. (2015:34), descriptive research exposes the true characteristics of persons, situations, and groups. Descriptive studies help to describe what happens (Grove et al., 2015:34). In this study, descriptive studies were used to describe

what was happening during the clinical practice of undergraduate nursing students in real situations.

3.2.3 Exploratory research

One of the advantages of exploratory research is the use of open-ended questions (Brink et al., 2018:141). This gave participants the opportunity to respond in their own words and it allowed for rich and explanatory responses. According to Polit and Beck (2017:15), an exploratory research design investigates the nature of the phenomenon and the processes by which the phenomenon is experienced. Exploratory research is done to gain insight into a situation. This exploratory design was used to satisfy the researcher's curiosity, since the students were complaining about placement areas. Hence, a problem was identified and this research project was undertaken. Exploratory research also allows for probing, that is, to ask: why and how? Participants will then elaborate on their answers (Mangal & Mangal, 2013:162; Brédart et al., 2014:4).

3.2.4 Contextual research

As a researcher, one's curiosity is to understand events, social processes, or a culture from the perspectives of the people who are experiencing the phenomenon (Grove et al., 2013:264; Gray et al. 2017:252). Context gives meaning to the events concerned so that the researcher can truly claim to understand the events (Babbie & Mouton, 2001:272; Amaresan, 2019). The researcher was triggered by the desire to know more about the experiences of student nurses during experiential learning. Contextual research means visiting or interviewing people in their everyday or natural environments (User research community, 2016). Contextual research can be used when you need to find out about user motivation or gain a wider sense of perspective on something and to know about pain points and moment of joy, for user experiences in real-life setting (Malpass, 2018). The desire to ascertain the challenges facing these students in their placement areas prompted the researcher's curiosity to commence this study among undergraduates at the Boland Overberg Campus in the Western Cape.

3.2.5 Population

Population refers to all the individuals about whom the research is concerned (Polit & Beck, 2017:249; Brink et al., 2018:116). It is the entire group of persons of interest to the researcher and who meet the criteria for the study (Grove et al., 2013:351; Polit & Beck, 2017:56). Sometimes population is referred to as the target population (Grove et al.,

2015:509; Haber, 2014:233). According to Haber (2014:232), a population is a well-defined set that has specified properties and can be comprised of individuals, animals, objects and even events. Polit and Beck (2017:739) reiterate this, stating that "a population is the entire set of individuals who have common characteristics". The entire population of this study included 184 student nurses registered under the R425 programme at the Boland Campus in the Western Cape. Participants were selected from second-, third- and fourth-year nursing undergraduate students, as they are the students who are exposed to experiential learning.

3.2.6 Sample

A sample represents a part of a whole or a subset of a larger set (Grove et al., 2015:511). Haber (2014:234) define a sample as a subset of a population selected to participate in a study. The sample of this study was a group of 38 nursing students from the second, third and fourth year, who were registered under the R425 programme at the Boland Campus in the Western Cape. This group of students had been exposed to clinical practice, therefore they were able to give information on their lived experiences during clinical practice in the healthcare facilities where they were placed.

3.2.7 Sampling

Sampling methods refer to the process of selecting a sample from a population to obtain information regarding the phenomenon, in a way that represents the population of interest (Haber, 2014:232; Polit & Beck, 2017:250).

Purposive sampling was used for this study and participants were selected from second-, third- and fourth-year nursing undergraduate students. The researcher used her judgement to select the participants. As these participants had clinical experience, they were best equipped to participate in this study (Gray et al., 2017:345; Polit & Beck, 2017:741). Participants were deliberately selected based on the knowledge of the topic the researcher believed they had, as they had already been exposed to experiential learning (Gray et al., 2017:345). The researcher chose purposive sampling because it involved conscious selection of subjects by the researcher. Choosing purposive sampling assisted the researcher in obtaining the in-depth information needed for this study (Grove et al., 2015:270). According to Omona (2013:179), Palinkas et al. (2015:534) and Polit and Beck (2017:493), purposive sampling has different strategies. Homogeneous purposive strategy was chosen for the present study to select participants for the focus groups, as these students were all undergraduate nurses (Holloway & Galvin, 2017:145). The researcher

focused on obtaining the best possible sample to ensure rich in-depth findings (Palinkas et al., 2015:534; Holloway & Galvin, 2017:145). Homogeneous sampling reduces variation, simplifies analysis and facilitates group interviews, as participants have the same characteristics (Palinkas et al., 2015:534; Polit & Beck, 2017:494).

3.2.8 Sample size

In qualitative research, there is no set rule for sample size (Haber, 2014:244). Grove et al. (2015:274) agree with Haber that the size of the sample needed is determined by the depth and richness of information required to gain insight into a phenomenon or to understand it. The goal is the quality of information obtained from the participants sampled versus the size of the sample. There is normally prolonged contact with participants. Small samples tend to be used owing to the large volume of data normally generated from interviews and that then must be analysed also (Haber, 2014:244). In qualitative research, the sample size is determined by the quality of information obtained and until data saturation has been reached (Toles & Barroso, 2014:101; Polit & Beck, 2017:60). In this study, the sample consisted of 38 students. During the recruitment process, 41 students were recruited, but at the time of the interviews, only 38 students were available. The other three students did not arrive to participate in the interviews. The researcher continued with data collection until the participants repeated the same information – this is called data saturation. The important thing in qualitative research is that there is no predetermined number of participants to be selected; sampling takes place until there is data saturation (Toles & Barroso, 2014:101).

3.2.9 Data saturation

Data saturation is when participants repeat the same information during data collection. It occurs when no new information is provided other than the repetition of previously collected data (Grove et al., 2015:274; Polit & Beck, 2017:497). Data were collected until no new ideas were forthcoming.

3.2.10 Recruitment of participants

Once ethics approval (see Appendix F) from the Cape Peninsula University of Technology (CPUT) ethics committee to conduct the study was granted, the researcher requested permission from the second-, third- and fourth-year lecturers to interact with their students. The researcher chose these groups of students because these students were eligible candidates who had already been placed in clinical areas and who had clinical experience

in healthcare services. The researcher presented the information about the study to all the second-, third- and fourth-year students and left the information sheet regarding the study, with all the relevant contact numbers, with each student (see Appendix A). The researcher made it clear to the students that participation was voluntary and that no one would be penalised, should they prefer not to participate. Information regarding this study was also posted on the noticeboards of the college, together with the researcher's contact details. All interested students were asked to contact the researcher if they felt inclined to participate in the study. Time frames in which they could make the necessary contact were also made known to the prospective participants. It was also stressed that interviews would not be conducted during times when students would be in clinical placements or in lectures. The researcher suggested times between 16:30 and 20:00. Participants were also informed that they could select a time that suited them. Confidentiality was assured. From the 185 students eligible at the Boland Campus, only 41 students responded to the researcher's invitation. All 41 students met the inclusion criteria and qualified to participate in this study; however only 38 students turned up for interviews. The students were males and females between ages of 19 and 37 years.

3.3 Setting

A research setting refers to a place where research is conducted (Grove et al., 2015:512; Polit & Beck, 2017:744). This study was conducted on the Boland Overberg Campus which is a semi-rural satellite campus of a university in the Western Cape. This campus is located in the Cape Winelands district in the Western Cape province of South Africa. Most of the nursing students came from this area, while a few were from the Eastern Cape. Most of the inhabitants in this area speak Afrikaans, and in most clinical placement areas Afrikaans is the main language of communication. Undergraduate student nurses from this campus are placed in accredited hospitals, day-care clinics and other healthcare facilities in this area.

3.4 Inclusion criteria

- All students in their second, third and fourth year of study and registered for the R425 programme (the course that leads to registration as a nurse (general, psychiatry, community) and midwife at the Boland Campus in the Western Cape.
- Participants needed to be 18 years and older.
- Participants included both male and female students.

3.5 Exclusion criteria

- All R425 nursing students who were under 18 years of age were excluded.
- All R425 undergraduate students doing their first year were excluded, as at the time of data collection, these students did not have sufficient exposure to clinical practice.

3.6 Data collection

Data were collected soon after the researcher received ethics approval from the CPUT Ethics Committee to conduct the research (see Appendix F). Permission and support were also granted by the head of the Western Cape College of Nursing (see Appendix C). Focus-group interviews were used as a mode of data collection. Focus groups were conducted between 25 November 2016 and 16 March 2017. According to Grove et al. (2015:204), focus groups are a measurement strategy in which groups are assembled to ascertain the participants' perceptions in focused areas in settings that are unrestricted and non-threatening, and are used in qualitative research. A focus group is a group five to eight people who have similar experiences with the same characteristics. If fewer than four people, the discussion tends to be inadequate (Grove et al., 2015:85). Focus groups are mostly used to collect qualitative data. In this study, focus groups were used to understand the experiences of undergraduate nurses during clinical practice in healthcare facilities.

3.6.1 Focus-group interviews

A semi-structured interview schedule was used to guide the interview discussions (see Appendix B). Semi-structured interviews allowed the researcher to ask a certain number of specific questions but also allowed the researcher to pose additional probing questions (Grove et al., 2015:83; Gray et al., 2017:264; Polit & Beck, 2017:510). The semi-structured interviews were organised around a set of open-ended questions. The researcher knew what she wanted to ask but could not predict the answers (Polit & Beck, 2017:510). Semi-structured interviews are sometimes referred to as 'guided interviews'.

Interviews were conducted in one of the study halls at the Boland Campus. This was the choice of the participants. This setting was non-threatening to the participants and conducive to the comfort of the participants (Grove et al., 2015:85; Gray, 2017:264). Signs informing people of the research interviews in progress were displayed to avoid disturbances and noise. According to Gray et al. (2017:263), each focus group should consist of 4 to 12 participants. Eight focus groups were conducted, of which six of these groups consisted of 5 participants each. The other two groups involved 4 participants only

as some students did not arrive for the interviews. These focus groups consisted of female and male students from the second-, third- and fourth-year levels of study. These focus groups were established according to all the students' availability. Two days before the interviews, the researcher contacted all the prospective participants to remind them of the interviews and time schedules.

The researcher went to prepare the hall at 14:30, prior to the commencement of the first interview, which was scheduled for 15:00. One big table was utilised and chairs were arranged around the table in such a manner that participants could face one another. With the first two groups, participants were identified as B1 to B5 and C1 to C4. The next six groups wanted to use pseudonyms for the sake of confidentiality, which the researcher allowed. However, during the reporting of the data process, the participant number, year of study and focus group number, e.g., P1-y2-Fg1, P20-y3-Fg4 etc., were used and no pseudonyms were referred to. This further secured anonymity.

Before the commencement of the interviews, the researcher welcomed the participants and introduced herself. She thanked the participants for attending and explained once again the issues of anonymity and confidentiality. Group rules were also established with the help of the participants and every group member was encouraged to share and participate in the discussions. The interview process was also explained, and participants were informed of the audio recording that would take place during interviews, for which they also had to sign consent. Written Informed consent was obtained from the participants for interviews (see Appendix A).

Introductions were done to familiarise the participants with one another. The groups who had requested pseudonyms were asked to introduce themselves using these. Open-ended questions were posed to the participants according to the semi-structured interview schedule (see Appendix B) (Polit & Beck, 2017:511). Interviews were conducted in English. During interviews, the researcher used good communication skills by maintaining eye contact. Throughout the interview process, the investigator respected the participants; for example, if the participants were not comfortable, the researcher did not do any further probing of individuals, but any group member could give input. The first two focus groups were conducted on 25 November 2016. The researcher was forced to stop the collection of data owing to the #FeesMustFall protests prevalent on all university campuses nationally. The rest of the data-collection process was from 13 February 2017 to 16 March 2017. An Olympus digital voice recorder was utilised to do all the recordings. Each interview lasted approximately 45–60 minutes. The length of focus-group interviews depends on the topic to be discussed, and 45–60 minutes was deemed adequate for the

participants to provide sufficient information or responses (Grove et al., 2015:84; Gray, 2017:263).

The following questions were asked in the same order of all the participants in the various groups.

1. Briefly tell us about yourself and why you chose nursing as your career.
2. How do you feel about being a student nurse generally?
3. In your own words, describe your learning experiences during clinical practice at health care facilities.
4. What were your most positive experiences and why?
5. Tell us about the challenges that you faced during this period of your study?

3.6.2 Probing

During interviews, probing can be used to obtain more information in a specific area of the interview (Grove et al., 2015:83; Polit & Beck, 2017:510). Participants were asked neutral questions to avoid bias. Questions such as, "Can you tell me more about what you just said?", "Can you clarify that for me?" Why do you say that? "How did you feel?" were used when required.

3.6.3 The moderator role

The moderator's role in this study was to ensure that the group discussions were conducted in a professional manner and fairly (Gray et al., 2017:264). The moderator in this study was a professional nurse with experience in research. She has a master's degree and during the collection of this data, she was busy with her PhD. The moderator was a silent observer, ensuring that the discussion went according to the written interview guide and that all participants were treated fairly and with respect (Polit & Beck, 2017:511). At the beginning of the interviews, the moderator assisted in establishing some ground rules. The participants were advised to respect each member in the group and requested that one participant speak at a time. The moderator explained to the participants the importance of confidentiality and of maintaining the confidentiality of what was said in the group. The moderator also ensured that no participant dominated the discussion. The moderator also made valuable notes in respect of the participants' body language and observed all cues well during the interviews (Mack et al., 2005:59-61; Gray et al., 2017:264).

3.6.4 Advantages of focus-group interviews

Focus groups assisted the researcher to obtain in-depth information on the experiences of these undergraduate nursing students (Grove et al., 2013:274; Polit & Beck, 2017:511). Information could be collected more rapidly during focus groups, compared with one-on-one interviews (Grove et al., 2015:511). During focus-group interviews, the researcher can observe participants' body language. Non-verbal responses of participants are also regarded as important information (Brink et al., 2018:144). Focus-group interviews help the participants to share their thoughts with one another. This sharing of thoughts assists participants to generate more ideas and consider more views before answering the researcher's questions (Brink et al., 2018:144). Interaction among participants can help them to express and clarify their views (Polit & Beck, 2017:511). Focus-group interviews assist the researcher to generate complex information at a low cost in a short time (Polit & Beck, 2017:511).

3.6.5 Disadvantages of focus-group interviews

The researcher should be skilled at facilitating focus-group discussions. Some important information may be missed because of a group member who dominates the discussion. Some people are shy, and uncomfortable speaking in groups. This can lead to bias because the results will be based on one person's comments (De Vos et al., 2011:374; Gray et al., 2017:264). Potential distractions include impending work when focus group interviews are done. Participants may be reluctant to criticise their office procedures for example, a student nurse may feel bad in criticising the mentor (Fetters et al., 2016:73). Focus-group data analysis is time-consuming and needs to be planned in advance. During interviews, there is a large amount of data generated. A one-hour interview could take four to five hours to transcribe in full.

3.6.6 Data protection and management

All information from the participants was treated anonymously and participants' identities remained secret. A hand-held recording device, with password protection, was used for recordings (Gray, 2017:268). All recordings were transferred to the researcher's password-protected laptop. A folder was opened where all the information was stored and this folder was encrypted (Gray et al., 2017:268). All the data were wiped off the recording device. All transcripts were locked in a safe in CPUTs Department of Nursing for five years and only the researcher and supervisor will have access to the data in future until all

publications are done. The researcher also used her office computer with password-protected access as a backup.

3.7 Data analysis

Data analysis is the process that brings order, structure and meaning to the mass of collected data (Polit & Beck, 2017:530). It changes data into findings. The gist of data analysis is to make sense out of text and image data (Creswell, 2014:195). Creswell (2014:195) further contends that data analysis includes breaking down and taking apart the data as well as putting it together. In qualitative research, analysis of data involves an examination of text instead of numbers and it goes hand in hand with data collection (Brink et al., 2018:46). According to Creswell (2014:195), in qualitative research data is so dense and rich that not all the information can be used. Thus, during data analysis the researcher needs to sort the data. The researcher can focus on the data and disregard other data that she could not utilise at the time of analysis (Creswell, 2014:195).

Recorded data from the focus groups were transcribed word for word by the researcher herself. This allowed the researcher to engage intensely with the data. This was done by listening to the focus-group recordings more than once, to clarify the typed transcriptions (Grove et al., 2015:88). The transcripts were read repeatedly until the researcher was familiar with the data. The researcher wanted to understand what participants (undergraduate student nurses) really felt and thought about their experiences during clinical practice.

The supervisor assisted with coding and the formulation of themes and sub-themes to avoid bias. Data analysis was done following Colaizzi's (1978) seven steps method of qualitative data analysis discussed in Polit and Beck (2017:540) which are:

1. All scripts were read in order to make sense out of them.
2. The transcriptions were reviewed, and important statements were extracted.
3. From the extracted statements, the researcher formulated meanings.
4. The researcher organised the formulated meanings into clusters of themes.
5. The researcher went back to the original transcriptions to validate them.
6. The researcher integrated the findings into an exhaustive description of the investigated phenomenon.

7. The researcher formulated the exhaustive description of the investigated phenomenon in such a way as to identify a fundamental structure.

The researcher went back to the participants and checked whether the transcripts represented what they had actually said. This is called member checking (Polit & Beck, 2017:564).

3.7.1 Member checking

In qualitative research, chances of bias are great, but the potential for researcher bias may be reduced by actively involving the research participants in checking and confirming the results (Birt et al., 2016:1802). Member checking is an important technique to determine the accuracy of qualitative results (Birt et al., 2016:1803). It establishes the credibility of qualitative data (Creswell, 2014:201; Polit & Beck, 2017:264). After transcribing the data, the researcher returned the verbatim transcripts to the participants to confirm if what was documented was what they had said. The researcher again took the final themes to the participants and obtained the participants' reactions (Birt et al., 2016:1803). Member checking has advantages and disadvantages.

3.7.1.1 Advantages of member checking

Member checking gives the participant time to correct errors and challenge what is perceived as wrong interpretation. Member checking provides an opportunity to summarise preliminary findings. It gives participants a chance to assess the adequacy of data and to confirm particular aspects of the data (Polit & Beck, 2017:572).

3.7.1.2 Disadvantages of member checking

Members may disagree with the researcher's interpretation and some participants might fail to disagree with the researcher's interpretation because researchers are seen as good scholars. The researcher is seen as more knowledgeable than the subjects. Different participants may have different views of the same data. Participants might say things during interviews that they later regret, hence, they might deny that information reflected is correct. Participants have the right to ask that information be removed if they are unhappy with what is recorded (Birt et al., 2016:1803; Polit & Beck, 2017:572).

3.7.2 Coding

Coding is the process whereby the data is organised so that it may give meaning to the researcher (Gray et al., 2017:673). Coding of data makes the underlying information or

messages portrayed by the raw data clearer to the researcher (Creswell, 2014:241). During the coding process, the researcher identifies and indexes recurring words, themes or concepts in the data. Saldaña (2013:16; Gray et al., 2017:271) states that the coding process can range from a single to a full paragraph on an entire page of text to a stream of moving images. The researcher used the word and typed the data on the left two-thirds of the page, while the right margin was used to write codes (see Appendix G) (Saldaña, 2013:16). The coding process assisted the researcher in organising and grouping similar coded data into categories which eventually synthesised into major themes (Gray et al., 2017:271).

3.7.3 Reflexivity

As a qualitative researcher, one must position oneself in one's writings. With reflexivity, the researcher is aware of the biases, values, and experiences that the researcher brings to qualitative research (Creswell, 2014:186). According to Palaganas et al. (2017:427), as researchers, we are part of the social world that we study, therefore it is important to examine the potential influence a researcher has on the study by doing self-reflection. The researcher is a lecturer in nursing, exploring the experiences of undergraduate nursing students. Some of the students that participated in this study were the researcher's first-year students. The researcher knew the students well, even though she was not involved with them during their experiential training. The researcher is the first-year lecturer, teaching anatomy and physiology. Although the researcher was not actively involved with second-, third- and fourth-year students while they were doing experiential training, and not teaching them during the year levels mentioned, she taught all of them in their first year. The researcher's main concern was her role as lecturer and researcher. This closeness between the researcher and participants made the researcher aware of the fact that she should maintain a reflective stance and present a true picture of the students' experiential learning experiences. The researcher kept a reflective diary throughout the research process. She documented all the identified themes and what influenced her thoughts and feelings (Polit & Beck, 2017:563).

During interviews, the researcher made use of clarifying questions when the participants mentioned information they assumed the researcher was aware of, for example, the participants mentioned "pen 1s" and "pen 2s". The researcher asked the participants to tell her what they meant by these terms. Right through the interviews, the researcher maintained a professional relationship with the participants and was able to bracket herself outside of involvement with the interviews.

3.7.4 Bracketing

Bracketing is the process of putting aside views and biases about the research topic. When doing qualitative research, the chances of being biased are immense. It is important for the researcher to step out of prior expert knowledge as well as personal bias (Polit & Beck, 2017:471). Bracketing assisted the researcher to minimise bias and not to have an influence at any stage of the research process. The researcher made a conscious effort throughout the research process to suspend all beliefs and prior assumptions of the phenomena being researched. The researcher remained disciplined and open minded throughout the research journey (Holloway & Galvin, 2017:222).

3.8 Rigor in Qualitative research

According to Streubert (2014:134), rigor in qualitative research is trustworthiness.

3.8.1 Credibility

Lincoln and Guba (1985), as cited by Polit and Beck (2017:559), suggest four criteria that develop trustworthiness of a qualitative research enquiry. These are credibility, dependability, confirmability, and transferability.

In qualitative research, credibility refers to the truth of the data and its interpretation (Polit & Beck, 2017:559; Brink et al., 2018:158). Credibility is used to judge the accuracy and correctness of the research findings (Polit & Beck, 2017:559). If research findings are accurate, they are considered valid. Member checks and peer debriefing are some of the techniques used to achieve the credibility of this study (Brink et al., 2018:111). After the transcriptions were done, the researcher made use of member checks using individual participants as it was difficult to find them as groups, to allow members to verify that the transcriptions were a true reflection of what they had said during the focus-group interviews (Toles & Barroso, 2014:115). Unfortunately not all group members were able to verify because some completed the programme and had left already. Out of thirty eight (38) participants, only thirty two participants were able to verify. According to Polit and Beck (2017:564), member checking can be done while collecting data by using probing questions. In this study, the researcher used probing questions to ensure that she understood what the participants meant. The researcher listened to audio recordings and compared these with transcripts, and all the necessary corrections were done. The researcher developed a summary of major themes and presented it to the participants. The supervisor helped with the coding of data to ensure the credibility of the findings. The

researcher also kept a reflective diary to avoid bias and subjectivity (Polit & Beck, 2017:562).

3.8.2 Dependability

The study is reliable if similar findings are obtained when the study is repeated (Polit & Beck, 2017:559). If research findings are repeatable, that means they are reliable (De Vos, 2011:420; Brink et al., 2018:111). Dependability requires an audit trail. All transcripts will be stored for five years in a locked safe in the nursing department, where the researcher was registered as a student. This means that at any stage, when required, these transcripts could be accessed and audited. To check the consistency of this study, the researcher together with her supervisor both coded the data from the transcripts to avoid bias during data analysis. The researcher also used her colleagues to do peer checking. Peer checking helped to identify categories not covered by the research question (Anney, 2014:279).

3.8.3 Transferability

Transferability refers to the extent to which the conclusions of the study are transferable to other contexts (Brink et al., 2018:159). This is acquired by providing a detailed database so that someone else can determine if the results of the study can be applied in another context or setting (De Vos et al., 2011:420; Polit & Beck, 2017:560). The researcher used focus-group interviews to obtain thick descriptive and in-depth data on the experiences of undergraduate student nurses during experiential learning. These transcripts will be stored in a locked safe in the nursing department where the researched data could be accessed when needed only by the researcher and her supervisor. The data will also be made available through publication in an accredited journal.

3.8.4 Confirmability

Confirmability entails the objectivity of the researcher and avoiding bias during data collection and analysis (Anney, 2014:279; Polit & Beck, 2017:559; Brink et al., 2018:159). Confirmability is proof that the results of the study presented are a true reflection of the data collected and not based on assumptions. Confirmability refers to the degree to which the outcomes or results of the investigation could be confirmed by other researchers. It also proves that the findings are not just the imagination of the researcher. There are a few techniques in qualitative research through which confirmability can be achieved, for example, triangulation, an audit trail and reflective journals (Anney, 2014:279; Brink et al., 2018:159). The researcher used the audit trail technique to check whether conclusions and

interpretations could be traced to the source. All raw data were audiotaped with the permission of participants and then transcribed verbatim before analysis. The supervisor also assisted with the coding of the data (Brink et al., 2018:181), after which various themes and sub-themes were identified (Toles & Barroso, 2014:102; Polit & Beck, 2017:59). The transcripts and audio recordings will be kept safe for five years in a locked safe at the university, to which only the supervisor will have access, so that these records can be used to cross-check whenever required. During interviews, member checking was done while interviews were in process.

3.9 Ethical considerations

Research ethics is the study of appropriate ethical standards for research involving humans. It includes the establishment of appropriate governance for such research (Polit and Beck, 2017:727).

As a lecturer, using students as participants in your study, could pose an ethical challenge due to a power relation status that could play a role. The researcher is the nurse lecturer, teaching Anatomy and Physiology to first year student nurses and not directly involved with 2nd, 3rd and 4th year students who were the participants of this study. Due to the fact that the researcher was not directly involved with 2nd, 3rd and 4th year students, who were the participants of this study, lessened the possibility of coercion on students to participate. During the recruitment process, the researcher used strategies to minimize the undue influence (see 3.2.10 recruitment of participants).

When the researcher was accepted to the university as a Master of Nursing student, the researcher applied for permission to conduct research to the Western Cape College of Nursing using their students as participants, and permission was granted (see Appendix C).

According to Ferguson; Yonge and Myrick (2004:59), using your students as participants in research study you assume double agency or divided loyalty and that can lead to conflict of interests and threats to ethical principles. Ethical principles that are at stake are recruitment (see 3.2.10 recruitment of participants), the informed and voluntary consent process (see 3.9.6 Informed consent), participant withdrawal, anonymity (see 3.9.2 Anonymity) and confidentiality (see 3.9.1 confidentiality).

The researcher started collecting data as soon as approval from the Ethics Committee of CPUT was granted (CPUT/HW- REC2016/H26) (see Appendix F).

According to Polit and Beck (2017:137) and Grove et al. (2015:98), the foundation for research ethics is formed by the Belmont Report, Nuremberg Code, and Declaration of

Helsinki. The Declaration of Helsinki was adopted in 1964 and last amended in 2013. The Declaration of Helsinki promotes the protection of human subjects from harm (Grove et al., 2015:96). The Belmont Report joined three broad principles on which standards of ethical conduct are based: beneficence, respect for human dignity, and justice (Polit & Beck, 2017:139).

Ethical principles of autonomy, informed consent, beneficence and non-beneficence, justice, respect for persons, and confidentiality were upheld throughout this study.

3.9.1 Confidentiality

The participants were assured that the information they shared would be confidential. Students were also advised not to discuss issues or to mention any names outside the interview hall after each interview. They were however informed that the researcher could not guarantee that students would not discuss details of the interviews afterwards. The researcher ensured that the data was safe and not accessible to unauthorised persons. All the information from the participants was treated anonymously and the participants' identities remained secret. The researcher reassured the participants prior the consent that college staff will not have access to the data, only the researcher and supervisor will have access to their data before publication. A hand-held recording device was used, and recordings were transferred to the researcher's password-protected laptop. A folder was opened where all the information was filed and this folder was encrypted. All transcripts will be locked in a safe place for five years and only the researcher and supervisor will have access to the data. The researcher also used her office computer with password-protected access as a backup since the laptop could be stolen.

3.9.2 Anonymity

The recordings and transcripts were kept nameless. The researcher upheld privacy in respect of all personal identification of the participants that arose during the interviews. During the interviews, the students sometimes called one another by their real names. Participants were addressed by pseudonyms in two groups. The names of the hospitals used in this study remained anonymous. Focus groups were numbered as Focus Group 1–8.

3.9.3 Respect for person

According to this principle, individuals have the right to self-determination. Humans are capable of controlling their destinies. Therefore, all individuals have the right to conduct

their lives as they choose, without external controls. Human subjects have the right to decide whether they want to take part in any study without fear of being penalised (Grove et al., 2015:98; Polit & Beck, 2017:140; Brink et al., 2018:29). The researcher informed all the participants about this study. All participants took part in this study out of their own free will. Participants were reminded during interviews that if they so wished, they could withdraw at any stage without being penalised or victimised. The objectives of the study were explained to the participants. An information sheet was given to each participant prior to the interviews and at the information session (see Appendix A).

3.9.4 Beneficence and non-maleficence

Beneficence is that ethical principle that aims to maximise benefits for study participants and non-maleficence is to avoid harm. A subject has a right to be protected from any form of harm (Polit & Beck, 2017:139). Harm can be emotional, spiritual, social or legal (Grove et al., 2013:174; Polit & Beck, 2017:139; Brink et al., 2018:29). The main issue here is that the researcher must protect the participants from any form of harm. Before the participants signed the consent form, the researcher answered all their questions in respect of clarification. During interviews, those participants who were uncomfortable about answering any of the questions were not probed or persuaded to do so. During interviews, the researcher observed the participants for any signs of distress. It was not necessary to interrupt any of the interviews, as there were no indications of any participants experiencing any levels of discomfort or distress. Should any participant have reacted negatively during the interview, he/she would have been referred to student counselling services at this campus (see Appendix E).

3.9.5 Justice

Justice involves the right of participants to fair treatment and the right to privacy (Polit & Beck, 2017:141). All subjects have a right to fair selection and treatment (Brink et al. 2018:30). To ensure justice, the researcher gave participants a fair chance to participate in the study according to the eligibility criteria. Four of the selected students who did not avail themselves for interviews, were treated in a non-prejudicial manner. The participants were all undergraduate student nurses from different beliefs, races, and backgrounds. All participants were treated courteously by not using racial or offensive comments. Group members were informed at the beginning of the interviews to respect one another's viewpoints and to give each member a fair chance to give his/her opinion.

3.9.6 Informed consent

Informed consent means that participants are well informed and have a clear understanding regarding the study (Polit & Beck, 2017:143; Brink et al., 2018:31). Participants can only make choices to take part to a certain study when they are well informed (see Appendix A).

Students who were interested, contacted the researcher and during this time the researcher explained the process to the students fully without pressurising or coercing them. During the conversation between students and the researcher, the researcher made it clear to the students that they are free not to participate and can withdraw voluntary at any point of the study when they felt to do so. The purpose of the study was explained to students during conversations and they were well informed.

The researcher also invited the participants to the study by writing. The invitation letter informed the participants of the purpose of the study, the voluntary nature of participation, what was expected of participants, how data would be collected, and the duration of interviews (see Appendix A). The participants signed a written consent form after the researcher had explained details again and after they had read the invitation letter. The participants were assured of anonymity throughout the interview process (Grove et al., 2015:106). Interviews were held on the college premises, as this was convenient for all participants. The hall was secure and private, away from other people and non-participating students.

Summary

Chapter 3 described how the study was approached and conducted. A qualitative method was used to explore and understand the experiences of undergraduate nursing students during experiential learning. Focus-group interviews were conducted to collect data. Rigour in qualitative research was discussed in detail. The ethical principles applied in this study were also interrogated and upheld throughout the study.

Chapter 4 is devoted to discussion and interpretation of results.

CHAPTER 4

Results

4.1 Introduction

The focus of this chapter is on the presentation and description of the results of the data collected from eight focus-group interviews.

4.2 Biographical data of the participants

The participants' demographic profile included the age, gender, and level of training of the participants. Focus-group interviews were held on one of the campuses in the Boland Overberg. Participants who took part in this study were in their second, third and fourth years of study. The total number of students who participated was 38. There were 14 second years, 16 third years and 8 fourth years. Ten participants were male and 28 participants were female. The participants were between the ages of 19 and 34. Eighteen participants were Afrikaans speaking, eight were isiXhosa speaking, one Sesotho speaking and one English speaking.

4.3 Themes and sub-themes

During data analysis, six themes emerged, and various subthemes were developed. A detailed description of themes and subthemes will follow with direct quotations that were quoted verbatim from the participants' interview transcriptions to provide an accurate description of their experiences. The themes and subthemes are presented in Table 4.1. Direct quotations from the focus group discussions will be referred to as follows: P-for participant; Y for the year of study and FG is for focus group e.g. P2-Y2-FG1

Table 4.1 Themes and sub-themes

Theme	Sub-themes
1. Clinical learning environment	Ward atmosphere Patient care Team work Interpersonal relationships Communication
2. Clinical teaching and learning support	1. Clinical teaching by ward staff 2. Clinical support from clinical educators/mentors 3. Peer support and learning
3. Learning opportunities	1. Involvement of students in teaching and learning activities 2. Clinical allocation 3. Practical opportunities
4. Inability to reach objectives	1. Inappropriate delegation of students 2. Shortage of staff in clinical settings
5. Enjoyable moments	1. Seeing patient recover 2. Being appreciated 3. Being accepted as a student
6. Challenges	1. Integration of theory and practice 2. Anxiety 3. Students were left alone 4. Violence 5. Congestion of students 6. Discrimination of students

4.3.1 Theme1: Clinical learning environment

4.3.1.1 Ward atmosphere.

During interviews, the effect of the ward atmosphere on nursing students' learning experience was clearly evident. The following confirm this:

“Yes, as a first year you are very scared and every time you see something negative, you know you will keep quiet because you are so afraid that they will be rude. They targeted me because I opened my mouth, and that is where everything started in the same ward I

was working, and I know that if one Sister is working, I know my day is going to be rough because she is always targeting me.” (P36-y2-Fg8)

“I think the Operational Manager can have a positive influence and should actually really be influential, and if she has a positive attitude, it’s so much easier for her to be approachable and accessible for you as a student.” (P12-y3-Fg3)

“They let the students run the wards and when you ask them stuff, they will have longer tea breaks and lunches, you feel so scared to interrupt them because you don’t know what the response is.” (P25-y4-Fg5)

Some of the staff were there to encourage the students:

“So my first day, it was very nice cause you’ve been orientated and some of the staff is like welcoming you and take you by the hand, but then there is some of the staff that are threatened by the students.” (P19-y3-Fg4)

4.3.1.2 Patient care

Participants were disappointed during placement because they witnessed the poor quality of care that patients received. This is what they had to say about patient care:

“The thing that put me off the most, was that everyone was so focused on their little routine every day that there was no time for building patient relationships and getting to know the patient.” (P5-y2- Fg2)

“... as a second-year student, I am working in a surgical unit, so this patient had a stoma bag which was leaking and the faeces spilled over the blankets. So the permanent assistant nurse said to me no we—ehm-- we are going to leave him to first put in a naso-gastric tube. I said to myself that the naso-gastric tube isn’t that important now, because how would you feel personally if you were lying in bed, you cannot do anything for yourself, lying in faeces.” (p38-y2- FG8)

“A patient passed away and I had an argument with Sister. She said the patient passed away after our shift so we must leave the body for the next shift and family was gonna visit the patient, and I felt that was not right.” (P23-y3-Fg5)

The students felt that ward staff was task orientated, instead of looking at the patient’s need.

“The one time also this patient went for a knee operation, so his whole foot was still full of that Povedine stuff and I wanted to wash it off because he asked me. As I went to get water

to wash his feet, the one Staff Nurse came in and she shouted at me, so I said I'm helping him, the patient wants to wash his feet but he can't bend his leg. So she told me, this isn't a spa, we don't do things like that, otherwise they make it a habit." (P12-y3- Fg3)

4.3.1.3 Team work

Students appreciated working together with other members of the multi-professional teams, as expressed in the following:

"... so I came into nursing and I witnessed a resus, and after that I said to myself that nursing is for me, because I saw how the healthcare professionals were interacting with one another to save that one person's life, and I thought to myself, I want to do nursing, I want to be part of that magical thing that happened." (P34-y2-Fg8.

"We sometimes lift the patients on our own and we don't have the knowledge of how to correctly lift the patient out of bed or take the patient to the toilet, and there was one physio in the medical ward, she saw we were struggling, and she just came to us and helped us move the patient and showed us the correct way so that we don't hurt ourselves." (P1-y2-Fg1)

Student nurses feel welcomed and accepted when clinic staff work closely with them.

"They made me feel welcome. They didn't say, oh, you're useless, you are not going to help us. They actually counted me in as a staff member and showed me everything." (P12-y3-Fg3)

"Yes, my greatest experience was when I worked in one of the wards here and the staff were so close with the students and we did everything together. When we fixed, they were there, when we needed something, they were there, and everything went so perfectly in that ward." (P36-y2-Fg8)

The ward manager plays a very big role in building the team spirit, as illustrated below:

"... whereas in a team that has a strong leader where the staff is united and they will say, I don't know this, but so and so knows it. I think if you should ask that person and then they will show you the right way." (P29-y4-Fg7)

4.3.1.4 Interpersonal relationships

During interviews participants repeatedly mentioned the issue of poor interpersonal relationships between clinical staff and students.

"I will say the greatest experiences are that you had to deal with the attitudes of the permanent staff, because a lot of times where I had moments where I just felt like quitting the course. It had something to do with the permanent staff's attitude and the way they do things, the way they talk to you; they talk down to you like you don't matter, you can't even think. They down-size you so much that you don't even feel human, you feel useless." (P29-y4-Fg7)

"I remember in surgical ward it's the most I think is the best ward to work in because you learn so much, yet it's the worst ward to work in, because the staff there are horrible." (P23-y3- Fg5)

"Actually, the staff is the main reason why I don't want to work in a hospital. That energy that they give off is just negative. You don't feel that you're learning anything." (P9-y2-Fg2)

According to the informants of this study, placement units are not the same. Some wards have good staff that are willing to help, while others are reluctant to assist students.

"It depends on where you are working, because in some wards the permanent staff is miserable, they undermine you; they don't help because they see you as at the lowest point of nursing. That is why most of us love working in the clinics, because it's nice to work there. I think most of us, when we are done, will love working in the clinic rather than in a hospital." (P8-y2-Fg2)

4.3.1.5 Communication.

Communication between clinical staff, clinical educators and student nurses was a challenge. The following confirm ineffective communication:

"... and also the writing, when you have to write the documenting; we're supposed to do the documenting at that time, so when I opened the documentation, the language was a problem. I didn't know what was written there because of the language. That was also a negative experience for me." (P32-y4-Fg7)

"The thing that was very negative was the staff. They think you are students you, you speak English? They aren't really interested in you but as much as you speak Afrikaans they would say oh, and they willing to teach you everything you need to know but English --- they won't say much to you. They are not willing to show you, to teach you how things are done in a hospital setting so that's the only negative thing to me." (P31-y4- Fg7)

The manner in which clinical staff addressed the student nurses was offensive as confirmed overleaf:

"So my name was not only thrown away in front of the staff but also in front of the doctors – now the doctors think I don't know anything, what is she doing here." (P23-y3-Fg5)

Listening is one of the communication skills important to nursing.

"Some permanent staff don't even want to listen if you say something. You can't even be the advocate for the patient because they don't want to listen and always say things like, 'Leave him or we will pay attention to him later.'" (P10-y3-Fg3)

Poor communication in clinical practice can lead to detrimental results:

"The physios use these water bottles where the people have to blow in, but they didn't explain to us what is that bottle for, so this was a really bad experience that I went through. I told the people who had the bottles that they must drink the water." (Laughs all around) (P25-y4- Fg6)

4.3.2 Theme 2: Clinical teaching and learning support

During clinical practice student nurses need all the support they can get from qualified staff.

4.3.2.1 Clinical teaching by ward staff

Participants revealed that professional nurses were reluctant to teach and support the student nurses because they were always busy with other duties.

"... And then you would come across Sisters who are not willing to help you as a student or explain things to you. That would shatter my whole self-esteem and I would lose my self-confidence." (P27-y3-Fg6)

“... like medication, we learn from the Staff nurses, yes, because the Sisters have paperwork or are busy with this and this, but the Staff nurses are always around.” (P5-y2-Fg1)

“... but then there are Sisters who are too busy. If you ask them, they tell you, I will find out and get back to you but they never do it.” (P9-y2-Fg2)

“It is that when you ask a Sister, please show me this or I need to do this, can she help me? Then some of them, not all of them, will say, No, I don't have time, go ask somebody else, and that's the thing. If somebody says that to me I will never ask that person again to help me; I'd just struggle on my own and get it right.” (P1-y2-Fg1)

Clinical areas where students were placed were different. In some areas clinical staff were willing to teach and support the students.

“I don't know how other people feel about it, but I noticed in Emergency that Sisters especially take time with you but in the wards it's always no, I don't have time, but it doesn't make sense because Emergency is supposed to be, there's patients coming now and we must help them, whatever, but they take the time to show you something, a procedure, and they don't rush it off.” (P12-y3-Fg3)

“Ok, for me in clinical practice neh, you will find Sisters who are willing to help you and to teach you the procedures, and then you find those sisters that don't have any time for you, they are just always rushing. It's busy, I understand, in the ward.” (P30-y4-Fg7)

“... some Sisters love teaching and you can see they love it. Others don't like students, they prefer to be on their own and do things on their own.” (P4-y2-Fg1)

4.3.2.2 Clinical support from clinical educators/mentors

The participants reported that clinical educators were not available and some mentors were not eager to support the students.

“In one hospital we only had three clinical educators, so it's a bit rushed with us. There are only three, and we are students from first year to fourth year, so they divide the students into how many practices and procedures we have. I think that's a negative thing, because

I think each year must have their own clinical educator because sometimes if we want a formative (when students want to practise) the clinical educators are not available because they need to do the procedures with the other years' students, and sometimes all three the clinical educators are busy with maybe the fourth years and we don't get the attention we need from the clinical educators.” (P1-y2-Fg1)

“Some of the mentors don't really support us and it doesn't feel like there is anyone to run to when we have problems. We just have to tell ourselves, this too will pass, I just have to finish my four years and get out of here.” (P27-y3-Fg6)

The participants in the current study acknowledged the work done by the clinical mentors.

“Our mentors play a big role in student learning because they are the ones teaching us how to do certain things in that particular year, e.g. in our first year they taught us how to do observations, every type of observation. In the second year they taught us how to give injections, put up a drip or something like that. So they obviously play a big role, because they are the ones teaching us and when we have procedures they will be the ones standing there with the marks. They play quite a big role.” (P1-y2-Fg1)

This study also revealed that owing to the large number of students, the clinical mentors came for clinical evaluations only. This is what they said:

“You know ma'am, our mentors come in and check if we are there, they do some papers, check if we have any problems, is there anything you want to know, but they don't physically teach us anything, they are only interested in the formative assessments.” (P8-y2-Fg2)

According to the participants, an inappropriate approach was evinced by the clinical educators when dealing with issues that affected the students.

“They [mentors] don't want to hear your side of it; they are all friends and they take their friends' side. You just have to keep your mouth shut and if you open it, you are wrong.” (P35-y2-Fg8)

“... so all in all I feel that the mentors are not fulfilling their duty to protect us as students. Secondly, I feel that most of us do not get to do certain things to be found competent in, because some of the staff aren't eager to help us.” (P15-y4-Fg4)

4.3.2.3 Peer support and learning

Students felt that the availability of other students around them lessened the amount of stress for them and increased learning, as expressed by the following:

“Other students, who are already experienced, helped us through the day, and told us, don't worry, tomorrow it will be fine and everything like that.” (P16-y3-Fg4)

This study revealed that to have other students in clinical placement areas is beneficial for their learning; it does not matter at which level the students are, because they provide a certain type of support. The following are the comments from the participants:

“So they taught me how to correctly admit a patient, how to make a bed; I don't know how many things, but they taught me how to do it physically, also how to wash a patient, so I learnt a lot from them in my first year.” (P4-y2-Fg1)

“I agree completely with X. When we started the first year, we knew the basics and we had an idea how to do them, but the other students helped us a lot with that. Because they are so much in the hospital, they learn it quicker. So they were very helpful.” (P5-y2-Fg1)

““But mostly when we were there, there were students who are coming from our campus so it was seen that there were other students from second year and further from our campus, so it was much easier because they were there to assist us.” (P31-y4-Fg7)

Most of the time clinical educators and clinical staff disappeared and the students (peers) were there for one another. One student confirmed this:

“But afterwards I thought that maybe it is because we feel so comfortable with our own kind who also doesn't know anything; we feel powerful when we are alone, but when we are with them we feel like nothing, not powerful.” (P34-y2-Fg8)

4.3.3 Theme 3: Learning opportunities

4.3.3.1 Involvement of students in teaching and learning activities

During clinical placement, students liked being involved and they liked challenging activities. In some cases, the ward sisters would drag the nurses to engage them in learning activities. The following are some of the comments from the student nurses:

“There was a boy, I can’t remember his condition’s name but it was very rare, and at that time I didn’t listen when they came to hand him over, and the sister came and asked me what they were saying and I told her, I’m sorry, I zoomed out for a moment and then she told me, go and study, and come and tell me tomorrow what it is. I went home but I couldn’t find it in the books because it is so rare, so I Googled it. The next day I told her what I had learned.” (P4-2y-Fg1)

“That was a most amazing experience because as students we were put in power and it felt as though we are in charge and it is our turn to show what we have learnt in the college we can put in our practical tasks.” (P25-4y-Fg7)

Nursing students liked autonomy; they liked to make decisions.

“At the particular clinic where we were placed we had lots of freedom and lots of responsibility so you get to function independently, and that is so, so nice.” (P14-y3-Fg3)

“I told the patient I am a student nurse and I am going to put in the drip, and the first patient said, No, it’s fine, you must learn. So I put in the drip and there was no air in the - -e, e-- what you call it? Vein, so she said it was good.” (P19-y3-Fg4)

4.3.3.2 Clinical Allocation

Participants in the current study were not happy about allocation.

“You know what? Also the allocation to the wards is weird. Sometimes we will spend a week in a particular ward and then at the end of the year you have to go there again. Why not group all those hours together, then you will get a better chance to get well acquainted with the staff and know their mood swings, you will know whose trust to gain so that they will give you more responsibility.” (P12-y3-Fg3)

“We also spend less time in the hospital, cause we only come there for two weeks, but in that time they don’t know how to approach us, then some of them are very rude, there is no other word to describe it.” (P7-y2-Fg2)

“We are being forced to go and work in different wards when we are allocated to a specific ward. The same happens on night shift. Someone doesn’t show up and you have to go and work. You don’t owe Medical hours but you have to go and work in the Medical ward. We are trying to learn but while we have to start in the Medical ward they are taking us out and putting us in the surgical ward because that is where they want us to start. That is the reality we are facing. This should really be addressed at a managerial level.” (P12-y3-Fg3)

4.3.3.3 Practical opportunities

Students are placed in clinical units in order to get practical opportunities, and to strengthen their knowledge and clinical skills.

“But there is never time to do our work; there is never time to walk with a medicine trolley, to get familiar with the medication.” (P15-y3-Fg4)

“There are some days that we can’t even practise a simple thing like washing hands before medication. We can’t do that because we are always busy doing other stuff.” (P34-y2-Fg8)

“I think the Sisters don’t allow us to practise what we are competent in. I often make a joke with my colleagues and say that we are going to be vital signs Sisters one day, because that’s all we know.” (P23-y3-Fg5)

“Just like in our third year we did like unit management; in nursing management you are sommer [just] being an acting sister: you need to go with a unit manager, you need to know the work they do like a Sister and copy what she does. We never got exposure – not even a tiny bit of how it is to manage a unit when you come in to do your unit management.” (P29-y4-Fg7)

“It’s like we had two types of students – the Pen students and us. I was about to do a procedure on one of the patients when another student said, ‘No, that’s my patient.’ One of the mentors asked who had the patient first and I said I had the patient first. There are

a lot of procedures that both of the groups of students have to do and there is not enough time and opportunity.” (P19-y3-Fg4)

4.3.4 Theme 4: Inability to reach objectives

According to the nature of the nursing profession, reaching clinical outcomes is part of any nursing programme. Hence, students are placed in clinical settings in order to achieve their objectives.

4.3.4.1 Inappropriate delegation of students

Students were unhappy, as they were not placed in areas to fulfil their objectives.

“In the hospital where I worked, whether you are first, second, third or fourth year, when you come to services you are expected to do vitals and to fix. You are not given – you are not being allocated specifically to the area where you need to be to achieve those objectives.” (P29-4y-Fg7)

“... also with me, practical is the way they do in terms they always want to not to let the students grow as the years go up [sic]. If you are second year, then they know that you must do second-year things, those procedures for second year, and even if they duty you on a working roster they are supposed to duty you as second year but what I experience mostly you're doing third year and then they will be dutying you in first year's procedures.” (P31-y4-Fg7).

“So, if we are allocated for two weeks, for half of that week if we are there for medication we are not allowed to touch that trolley, you must insist to the sister to put you on medication; they want to do it themselves.” (P7-y2-Fg2)

4.3.4.2 Shortage of staff in clinical settings

Students did not learn as much as they expected to learn, as they were used as workforce on the wards.

“The other thing about us students is that we don't learn the stuff we are supposed to be learning in the clinical area because we are doing the work of the permanent staff.” (P32-y2-Fg8)

"When we come into service, we have a specific task we need to do there. But when we come in the wards, and when we tell them this is what we need to do, so the routine of the wards will be affected, because they are short-staffed and now we are coming and we are scheduled to be in that specific ward." (P7-y2-Fg2)

"Most of the time we as students are allocated to do observations. I am now a third year and when I go to hospital now I will be expected to do observations. So, we have certain assessments that we have to do each and every year, so they will allocate you to an observation. You will never get a chance to do medications or something which you have to do on a year of practice in third year to do certain assessments." (P11-y3-fg3)

4.3.5 Theme 5: Enjoyment moments

Even though the students had challenges during placement, there were times where they felt good and satisfied.

4.3.5.1 Seeing patient recover

The study revealed that nursing students feel good when they see their patient recover.

"They also gave up on her because she didn't even look at them. Her condition was just deteriorating; they even moved her to an isolated room so that she can be alone if she dies. (YENE!) (EXCITED also clapping hands.) That woman recovered, she was even shouting at us now but the thing is I didn't take that personally; I loved it because I know where she came from. Yes, she was skelling [shouting at] the nurses. Now she was shouting at us, but I didn't care, because I was just astounded that she had recovered." (P34-y2-Fg8)

"I think for me working with patients is always pleasurable, whether that patient is difficult or not." (P14-y3-Fg3)

"Helping the patient recover when they had an illness, explaining to them why they had the illness so that they can understand the importance of taking their medication. So, in that sense I love helping patients." (P4-y2-Fg1)

"I remember this little black baby, very very sick, meningitis, and she didn't allow anyone to touch her because she was very sick. Three weeks later she was so happy and energetic, she was running around the ward and jumping into everyone's arms; it was the most beautiful thing." (P23-y3-Fg5)

4.3.5.2 Being appreciated

Students like being appreciated, as stated by some of the participants:

"... and if you ask them something, they will do it, and they will thank you for everything you did in that shift, they appreciate it. Yes, we appreciate your help. And you are actually a good part of the team, you helped." (P35-y2-Fg8)

"I thought she will not make it and go home again, then after I started talking to her and treating her, she got better and she went home. She was the nicest patient I had ever seen. We talked every day, and she wants to help you, and if you did something small for her, like just giving her a glass of water, she would say, thank you, I appreciate it. That was very nice to work there for a week." (P35-y2-Fg8)

"She was also a first-year student, doing home-based care, and she complimented me." (P38-y2-Fg8).

4.3.5.3 Being accepted as a student

"It was so amazing, they helped me through the whole process and explained everything. Even the doctors were nice to me that night. I couldn't – Ja, it's like an unexplained feeling I will never forget." (P16-y3-Fg4)

"She said, go do this, go do that, she showed me what to do and I was feeling part of the team." (P20-y3-Fg5)

4.3.6 Theme 6: Challenges

During clinical practice student had to deal with different challenges.

4.3.6.1 Integration of theory and practice

"Focusing on their routine work, as they took care of the patients, that wasn't something I learnt from class, because last year we learnt about improving the quality of life of the patient and communicating with the patient but if we are communicating with the patient and someone or the Sister sees us, the Sister, they basically say, Come, you need to work, you can't stand and talk all day." (P5-y2-Fg1)

"I mean like the slightest thing, because if they learnt [sic] us there is somewhere a gap because they teach us how to make a bed, and when we get to the ward, they decide no

we're doing [it] this way, so there is slightly a difference between what we are taught and what is done in a hospital.” (P16-y3 Fg4)

“Sister shows me, e.g. how to put in a naso-gastric tube. During the demonstration they told us to wear sterile gloves, then when the Sister does it, they use normal gloves, and the whole procedure for that is not aseptic. Then you feel this is not the right way, but this is how the Sister does it, then you don't want to speak up or tell the Sister they are doing it the wrong way.” (P27-y3-Fg6)

4.3.6.2 Anxiety

“I was just so scared that I might kill a patient by doing something wrong; or doing something so wrong that I am asked to just stop training and leave.” (P29-y4-Fg7)

“I felt anxious most of the time because it's a patient's life that you are working with and you need to treat that patient so that they can go home and treat themselves with their condition and you must help them to treat themselves. That made me anxious, because it's a life, it's not just admin work.” (P1-y2-Fg1)

“... yes, Sister, and it's very scary as well because we are dealing with people's lives. Even if we give medication via a different route, even if it's still in the body, you don't know if it will have the same effect it has to have for the patient, so I have to say there was a lot of times I made terrible mistakes and I prayed that everybody stayed alive.” (P25-y4-Fg6)

4.3.6.3 Students were left alone

Most of the students felt they were left alone while in clinical placement. They had to do the work all alone without supervision of ward staff. This was evident by the following statements from undergraduate student nurses:

“We are a working force; the other day eh – me and Taylor were working night shift and this Staff nurse took off her shoes and sat by the nursing station the whole night while we were working. She actually told us in our face that we are there and they can rest when we are there so, we worked alone. She just sat by the nursing station, sleeping, talking, sleeping, maybe going to the toilet, so we are seen as a work force, and not students.” (P21-y3-Fg5)

"In the mornings there are four students, and all the students do the vitals and the washing and the permanent staff sit in the kitchen and catch up for the weekend." (P23-y3 -Fg5)

"We started off and I had to introduce myself to everybody and I said it's my first time working there, so I don't know anything, and everybody said, don't worry, we'll show you everything, everything, will be fine. Then we started working, but numerous times I would work with a patient and walk out of the room and I won't see anybody, it's only me." (P13-y3-Fg3)

"They think you can do everything, so they will sit there and leave you on your own to do everything, take the patients to theatre, wash the patients, do the vital signs, everything on your own, while they just sit there and drink tea the whole day." (P36-y2-Fg8)

4.3.6.4 Violence

"The other one was where a doctor threw gauze that was blood stained on my chest. She just threw it up in the air and it landed on my chest." (P9-y2-Fg2)

"I was sexually harassed in my second year by a security guard of the hospital when we were alone. I don't know if you know the Hospital H set-up, but it is the hospital and then across the road is the psychiatric wing. I was delivering the keys to the wing and I was alone with the security guard and he picked me up and pinned me against the wall and then he started feeling my body. That was also very emotional for me because I didn't know how to handle it or who to go to." (P23-y3-Fg5)

"Then you would allow the one student to use the Dinamap, but when I touch that Dinamap he would scold me and he was so rude to me, he would swear at me in front of the patients. I was so hurt, he was really scarring my self-image and how I think about myself as a student nurse." (P26-y4-Fg6)

4.3.6.5 Congestion of students in clinical setting

Large numbers of students in one placement area decrease the learning opportunities of the student nurse. Below are the comments of the participants:

"In one hospital we only had three clinical educators, so it's a bit rushed with us. There are only three, and we are students from first year to fourth year, so they divide the students in how many practices and procedures we have. I think that's a negative thing, because I

think each year must have their own clinical educator because sometimes if we want a formative the clinical educators are maybe not available because they need to do the procedures with the other year's students, and sometimes all three the clinical educators are busy with maybe the fourth years and we don't get the attention we need from the clinical educators.” (P1-y2-Fg1)

“I haven't had a good experience in hospital. It's like we had two types of students, the Pen students and us. I was about to do a procedure on one of the patients when another student said, ‘No, that's my patient.’” (P19-y3-Fg4)

“In the hospital we are up to seven students in a ward from first to fourth year, so there is one or two Sisters in the ward, excluding the Operational Manager, of course, so it's difficult for her to teach a first year and a second year at the same time, because it's two different things.” (P1-y2-Fg1)

“I think they should not put so many students in one ward because as I said, there were about sixteen students plus it was first years, second years and the hospital students and the permanent staff is also there. We don't know what to do, we don't know the other staff, and we can't go to another ward because we must work there. So, I don't think they must put so many of us (students) together.” (P2-y2-Fg1)

4.3.6.6 Discrimination against student nurses

This study revealed that undergraduate students were being discriminated against.

“The hospital students get the most support in the hospital if they want to do a procedure, but if our college students want to go and do a procedure, they don't get the same support.” (P6-y2-Fg2)

“There is a constant comparison between us and the Pen students, which I think is ridiculous. You cannot possibly expect of us to be able to do those things, and first of all, nobody takes us by the hand, not even half the time that they work, so obviously they will know the tricks of the trade. We sometimes struggle with the machines but they know the tricks of the trade and they could just show us how to work them. We are there for a number of days and just when you start getting comfortable with the staff in that particular ward, you have to leave already” (P12-y3-Fg3)

“He [registered nurse] was so biased. If he was using something, e.g. we were not allowed to use the Dinamap, we were supposed to do it manually, but other group of students from the hospital were using it. I found this unfair because in an ortho ward there is so many patients, how must we do it?” (P26-y4-Fg6)

“The following day it was her again. She was just like the Pen students were friends, were talking, showing them the stuff they already know, even if you stand next to her she will call those Pen students to come and help her and didn’t want us anywhere near her.” (P30-y4-Fg7)

Summary

In Chapter 4, the data collected from interviews were organised into themes, with the corresponding responses of the participants to support the identified themes and sub-themes. In Chapter 5 the themes and findings are discussed in accordance with the existing literature.

Chapter 5

Discussion of Results

5.1 Introduction

In this chapter the themes are discussed and integrated with relevant literature to contextualise the findings. The purpose of this study was to explore and describe the experiences of undergraduate student nurses during clinical practice in healthcare facilities in the Boland Overberg area.

5.2 Themes

5.2.1 Theme 1: Clinical learning environment

The clinical learning environment plays a big role in nursing students' learning. According to Bigdeli, et al. (2015:2), if there is any deviation from the actual and expected clinical environment, it will decrease the students' interest in the clinical environment. This could have a negative impact on their clinical performance. According to Wawire (2014:30), the quality of student nurse's clinical experience and outcome and the competent professional nurse later in the development of the nursing profession, is determined by the quality of the clinical learning environment. Negative clinical learning environment experiences, may influence the students' nurses' professional identity (Hsu et al., 2018:435).

The clinical learning environment is where students are exposed to real patients, where they not only learn to apply their knowledge and skills, but also learn the culture of the nursing profession (Mothiba et al., 2012:195; O'Mara et al., 2014:208; Watson-Miller, 2015:28). It is in the clinical learning environment where students learn how to apply nursing knowledge, nursing skills, patient communication and professionalization (Bigdeli, et al. 2015:1). When student nurses are placed in a conducive learning environment, they get the opportunity to learn from different people, including service users and other students (Lidster & Wakefield, 2018:5). The clinical learning environment is an interactive network of forces within the clinical setting. It includes staff, patients, clinical mentors and peers that influence the clinical learning outcomes and have an impact on students' behaviour (Watson-Miller, 2015:28). In this environment, interaction between different role-players, is very important for these students to grow and develop as competent practitioners (King in George, 2014:260). According to Tiwaken et al. (2015:67), the clinical learning environment is unpredictable and out of the clinical instructor's control. Therefore, it is very different from the classroom and can be a major shock for students. In a study done in Sweden and by Bisholt et al. (2014:304), students described a good clinical

learning environment as one where there is cooperation among staff. These findings contradict the results of this study, where the students reported that in most wards there was conflict among the clinical staff. However, participants in this study claimed that the clinical learning environment was an integral component of student learning in practice where they could apply their knowledge and skills if they were supervised and mentored appropriately. This is supported by Kaphagawani (2015:217); Jahanpour et al. (2016:1); Motsilanyane (2015:78) and King, cited in George (2014:260), who agree that students should be allocated to relevant real-life settings (the clinical environment) in order to apply theory into practice.

Billings and Halstead (2009:311) and Abouelfetoh and Mumtin (2014:491) view the clinical environment as double structured. It consists of a learning environment that includes the ward atmosphere, the culture, and the complexities of care. The other is that of the supervisory relationship between students, clinical, and school staff. A good-quality environment is determined above all by a good atmosphere in the ward (Mothiba et al., 2012:195; O'Mara et al., 2014:208; Watson-Miller, 2015:28). An environment where clinical staff are happy and friendly, with good morals and attitudes, enhances the learning of a student nurse (Henderson et al., 2012:301; Kaphagawani, 2015:223). King, cited in George (2014:258), describes these characteristics as reciprocal, as all role-players in this relationship may be a giver at one time and a taker at another time. In such an environment, staff are willing to guide students in how to provide quality patient care. According to the participants in this study, the clinical learning environment is an important factor in relation to the clinical learning of the student nurse and learning outcomes. A positive learning environment that is conducive to learning should help learners achieve their programme outcomes (Billings & Halstead, 2009:311; Pama, 2017:48). In the current study, the participants found the learning environment not conducive to learning. These findings were similar to those of Cunze (2016:85), who reported that the clinical learning environment was negative and not conducive to the learning of a student nurse. The findings of this study are similar to those of Neshuku & Amukugo (2015:93), who found that the clinical environment was not conducive for the learning of student nurses due to a few challenges, like the shortage of clinical staff and the negative attitudes of the clinical staff. If the environment is not conducive to and not supportive of clinical learning the students cannot have effective clinical preparation (Lekalakala-Mokgele & Caka, 2015:1). Students cannot have effective clinical preparation if the environment is not conducive to and supportive of clinical learning. In contrast with the current study, Vermaak (2013:81); Borrageiro (2014:4) and Pama (2017:48) found that the learning environment was experienced by student

nurses as conducive to learning. According to the results of this study, the clinical learning in different placement areas was not the same. In some units, it was positive and conducive to learning, whereas in other areas, it was negative and discouraged learning. Corrin (2016:110) in her study concurs with these findings, that some placement settings offer a more positive learning environment than others. According to the participants, staff attitudes contribute to a conducive or non-conducive environment for learning. These findings are similar to those of Kaphagawani (2015:227), who reported that poor relationships had a negative impact on student learning. According to this researcher, poor relationships between clinical staff and students led to an inimical environment, hindering effective clinical learning. Pama (2017:49) contends that a positive clinical learning environment supports student nurses in the integration of the theoretical and clinical components and that this type of environment is regarded as the ideal place where students can apply cognitive knowledge. Nikkinen and Ngoc Le (2016:11) revealed that even though clinical environment is important for clinical learning of undergraduate nurse, health care settings are not always conducive for learning.

5.2.1.1 Ward atmosphere

A positive atmosphere, driven by a good team spirit, plays a significant role during the placement of the student nurse (Jokelainen et al., 2013:65; Zenani, 2016:38). The findings of this study revealed that the atmosphere of the ward, where experiential learning took place, was very important. It played a major role in contributing to a positive or negative learning environment. According to Kaphagawani (2015:218), students should not be afraid to ask questions pertaining to their clinical learning, otherwise they will lack direction, and this would impact negatively on their learning. The aim of Goal Attainment Theory is to reach the goal. In this case, the student nurse has the goal to achieve which is to complete the nursing programme and to be a competent professional nurse. Interviewees noted that the ward atmosphere was not student friendly. They were scared to approach the clinical staff, and staff had a negative impact on their learning. According to King, cited in George (2014:258), role reciprocity is important. Students, however, did not experience this in the wards. They were eager to care for their patients, but the staff were not accommodating, hence students were scared to approach them for assistance. This study is consistent with the findings of Moonaghi et al. (2015:4), Kaphagawani (2015:218) and Zenani (2016:56), who stated that the ward atmosphere was not supportive in enhancing the learning process. These findings are also consistent with those of Bisholt et al. (2014:308) that a negative ward atmosphere militates against the learning of nursing

students. The current study revealed that students like a welcoming clinical environment where the staff shows interest in them. This was supported by Cooper et al. (2015:1005), Chuan and Barnett (2012:193) and Arora (2015:21), who reported that a welcoming ward atmosphere encourages students to learn. According to Arora (2015:21), a good ward atmosphere is where students are seen as less experienced colleagues and treated as such, and where the environment is described as favourable to student learning. The participants in this study felt that ward managers had a major role to play with regard to negativity and positivity in the ward atmosphere. According to the participants, the operational manager can be influential, and with a positive attitude, it is much easier for students to approach her. Participants confessed that they were scared to approach the clinical staff and that had a negative impact on their learning. This study is consistent with that of Moonaghi et al. (2015:4), that the ward atmosphere was not supportive in enhancing the learning process. According to Rajeswaran (2016:475), the ward manager should strive to create an atmosphere that will maximise the learning experiences of the student nurse. Mažionienė et al. (2018:662), reported that students who were supervised by ward managers during their clinical practice specified that there was a negative atmosphere in the wards, compared to those who were supervised by the ordinary registered nurses. Student nurses supervised by registered nurses felt comfortable going back to the ward at the beginning of the shift. According to these student nurses, when the atmosphere is positive, students learn effectively, and also learning opportunities are sufficient.

5.2.1.2 Patient care

Student nurses appreciate and value the environment where patients are treated with care and humanity (Nyelisani, 2016:88). According to Abubu (2010:66) and Weurlander et al. (2018:77), if quality care is poor, students feel emotional, and that impedes their learning process. Clinical staff should behave well, show respect and give hope to hopeless patients (Nyelisani, 2016:77). In the current study, it was found that the quality of patient care was poor, and clinical staff were also disrespectful towards patients. According to Grissinger (2017:74), disrespectful behaviour of clinical staff undermines the patients' confidence making patients scared and less likely to ask questions or give information. In the current study, it was found that the quality of patient care was poor and staff were also disrespectful towards patients' needs. Similar results were found by Weurlander et al. (2018:77), who reported that healthcare professionals behaved badly towards patients and did not meet the patient's needs. Clinic staff neglected to do certain things for the patients, which students felt that was humiliating for the patients. This is what one of the participants had

to say “... as a second-year student, I am working in a surgical unit, so this patient had a stoma bag which was leaking and the faeces spilled over the blankets. So the permanent assistant nurse said to me no we—ehm-- we are going to leave him to first put in a naso-gastric tube. I said to myself that the naso-gastric tube isn't that important now, because how would you feel personally if you were lying in bed, you cannot do anything for yourself, lying in faeces.” (p38-y2- FG8)

Members of the focus groups agreed that these attitudes and behaviours of senior staff members affected their learning negatively. They reported that ward staff would sometimes become angry with them when they were communicating with patients. The ward sister would tell students not to stand and talk to patients. However, King, cited in George (2014:263), encourages a good nurse-patient relationship in order to communicate information that is helpful in setting goals for the patient. This was consistent with Salehi et al. (2016:183), who reported that the ward sister would get angry if students spoke to patients. The strength of the learning experience in a clinical setting seems to be due to the focus on adapting care to the patient's needs. King, cited in George (2014:262), and Nielsen et al. (2019:38) agree with Salehi et al. (2016:183) that the ward sister is a registered practitioner that should be skilled in providing expert services to patients. The registered nurses in the ward did not fulfil their duties towards the student nurses, as was revealed in this study. In a study done in Barbados by Watson-Miller (2015:164), it was found that the care given in that health facility was patient centred. However, in this study, and in a study done by Zenani (2016:47), the opposite was revealed by students. They experienced staff to be task-based orientated rather than care orientated. The student nurses voiced that this task-orientated care affected their learning negatively as they were taught to focus on the patient's requirements only. Students felt that they did not give quality care in a holistic manner to the patient. In a study done by Fallon et al. (2018:52) in Ireland, it was found that patient care was organised around the ward schedule, instead of the patient's needs. In a study done by Weurlander et al. (2018:77) in Sweden, it was found that health care staff lack empathy towards patients. This study concurs with the above authors, as illustrated by a participant “I don't like working in IDC (intellectual disability clinic), because not that I feel it is wrong, but they don't know what is going on around them, some people (nurses) treat them badly because they know they don't understand and can't speak up for themselves, now they abuse it and treat them badly.” (P24-yr3-Fg 6)

5.2.1.3 Team work

According to Jooste (2018:159), a team is a group of individuals working independently to achieve a common goal. Good team work is characterised by a high level of participation by all members, support for innovation, clarity of team objectives, task orientation and mutual role understanding (Jooste, 2018:160). Goal attainment theory emphasises the importance of working together as clinical staff and student nurses (King, 1981 cited in George, 2014:257; Wayne, 2014). When the parties involved work together as a team, it is easy for them to plan and set goals so that it will assist the student nurse to become competent. When students and clinical staff work as team, clinical staff become role models for student nurses. During this interaction clinical staff assists student nurses to become competent and to enable these students to produce the highest level of quality care. The undergraduate nursing students want to be accepted and work as part of the nursing team. Jooste (2018:163) agrees with the current study, stating that if the members of the team are part of the group, their self-esteem is boosted.

Feeling included and valued in the ward improves the student's self-esteem and confidence (Dale et al., 2013:7; Phuma-Ngaiyaye et al., 2017:167). According to the participants in this study, nurses need to work as a team together with other members of the multi-professional team. It was evident that working with other members of multidisciplinary teams enhances the learning of a student nurse. Multidisciplinary team members work well together because they all have one goal (Du Toit, 2013:53; Lidster & Wakefield, 2018:15; Jooste, 2018:159). The multidisciplinary team brings knowledge and information to the relationship that will support the identification and development of interventions to attain set goals (George, 2014:273). The commitment of one member of the team, needs a shared commitment from all other team members (Mntambo 2009:134; Dixon & Wellsted, 2019:7). The results of this study revealed that students appreciated working together with members of the multi-professional teams. Cunze (2016:78) agrees with the above findings concurring that well-functioning multi-professional teams are key to delivering effective and safe healthcare.

The current study revealed that the members of the team, led by a strong and dedicated nurse manager, are united and that results in an environment conducive to learning. The findings of this study revealed that students felt safe when they worked with registered nurses as a team. Similar findings were reported by Nyelisani (2016:79) and Watson-Miller (2015:130), who stated that student nurses wish to work with registered nurses in harmony as a team. These authors believed that the second feature of a good ward team interaction was the ward sister functioning as a team player. It was found that undergraduate nursing

students want to be accepted and work as part of the nursing team. Watson-Miller (2015:173), Arora (2015:22) and Jokelainen et al. (2013:65) concur by stating that student nurses perform at their highest level when they are engaged in the team.

5.2.1.4 Interpersonal relationships:

Kings' theory of goal attainment is based on personal, interpersonal and social systems (George, 2014:260). According to King's theory of goal attainment as cited by George (2014:260), the interpersonal systems are formed by two or more people. In the current study, the interaction is between undergraduate student nurses and clinical staff. This interaction between the nursing student and clinical staff affects the learning of the student nurse whether negative or positive (King, 1981 in George 2014).

A study done by Mikkonen (2016:173) revealed that clinical learning of student nurses is influenced by clinical staff attitudes. According to Labeeb et al. (2017:152), staff–student relationships are important to the student's experience of belonging and socialisation. According to Wayne (2016), creating relationships and membership in clinical settings, are crucial. When the relationship between the clinic staff and the undergraduate nurses are stable and healthy, students' opportunities to learn, are high (Liljedahl, 2018:274). In a study done by Neshuku and Amukugo, (2015:94), student participants reported that interpersonal relationships between clinical staff and undergraduate nursing students, are not always what it should be. Hence, it has a negative impact when it comes to learning of students. In this study, most of the students experienced inappropriate interpersonal relationships with clinical staff. These findings also concur with those of Rikhotso et al. (2014:3), Matshotyana et al. (2015:118) and Mamaghani et al. (2018:219), who stated that relationships between nursing students and ward staff were poor. Disrespectful and mean behaviour, lead to a negative relationship between the student nurses and professional nurses, and this negative attitude of professional nurses, reduces the student nurses' trust and respect for professional nurses (Rikhotso et al., 2014:3).

A study by Jack et al. (2017:4712), revealed that students were exposed to negative behaviours which might lead to students imitating such practices. This might lead to poor nursing practices and poor outcomes for both the students and the patients, as well as the rest of the team.

According to the participants of this study, student nurses were disrespected by hospital staff. This is evident in the following quote: "*Some people they don't know how to speak to us. I feel we are all human, and even though some of us are much older, it doesn't matter how young or old we are, I still need to be spoken to with respect. Cause is like waars die*

student they shout at us but like why this isn't done, but I don't feel that it is right. Respect comes from both sides. They want to be respected, but they don't respect us" (P15-y4-Fg4). Similar findings were reported by Motsilanyane (2015:83) where the student nurses reported that clinical staff were disrespectful, unapproachable and shouting at students when they did something wrong without listening to what students had to say or explain about it.

Student nurses are influenced by the relationships they have with clinical staff in the placement area as well as by their learning and sense of self (Nabolsi et al., 2012:5854; Dadgaran et al., 2013:6; O'Mara et al., 2014:211; Mamaghani et al., 2018:219). King's theory, cited in George (2014:257), places a strong emphasis on interpersonal relationships by human beings interacting with one another. This theorist claims that these relationships are characterised by different values, mechanisms for forming these relationships, the experience of those persons forming the relationships, and finally, how different perceptions influence these relationships.

Attitude of the hospital staff towards undergraduate nursing students is one of the main factors that has a negative impact on student's learning during clinical practice. In a study done by Mueller et al. (2016:4) in Midwest US, students reported that hospital staff had negative attitudes towards student nurses. This type of relationship may have a bad influence on the experiences of these undergraduate students in the clinical learning environment. King's theory of goal attainment as cited by Gonzalo (2014) emphasises the importance of the undergraduate student nurses and the clinical staff to make mutual decisions and setting of mutual goals. The current study revealed that staff attitudes and perceptions had a negative impact on the learning of these nursing students. The two parties, that is student nurses and clinical staff, failed to set goals and make decisions together. Students were ignored by the clinic staff, even when they asked for help. Instead, these students were ridiculed. This is what one of the student had to say: *"They were rude to me, they were unprofessional to me, no-one orientated me, they spoke to me as though I was a retard; I'm sorry to say that but that's how they spoke to me, there was no respect for me. So, my name was not only thrown away in front of the staff but also in front of the doctors. Now the doctors think I don't know anything, what is she doing here?"* (P23-y3-Fg5)

This statement clearly does not conform to what King expresses as important in forming good relationships to attain goals set towards the healing of the patient (King in George, 2014:273). These findings are consistent with those of Mothiba et al. (2012:202) and Lee

et al. (2018:107), who reported that poor interpersonal relationships between clinical staff and student nurses in placement areas hinder the learning process of student nurses. It also does not set a good example to these students in forming good relationships and developing interpersonal skills. During the interviews, some participants reported that they wanted to quit nursing because of the negative attitudes of staff towards them. The current study is consistent with that of O'Mara (2014:210), who reported that relationships with clinical staff were a major challenge affecting students' learning and interpersonal relationships. The findings of this study revealed that owing to the negative attitudes of clinical staff, students were discouraged from asking questions when they had problems during clinical practice in the wards. An unsupportive negative attitude results in the deterioration of the educational quality in the clinical environment and this discourages nursing students (Matshotyana et al., 2015:118; Motsilanyane, 2015:84). According to Jokelainen et al. (2013:65), unwillingness to interact with nursing students can restrict their experiential learning as well as their attaining their goals of growth and development (King, in George, 2014:260).

5.2.1.5 Communication

Communication is a process whereby information is exchanged and understood by two or more people and is commonly used to motivate or influence behaviour. Communication is the corner stone of nursing services (Jooste, 2018:230). According to Mikkonen (2016:181), differences in language and culture in healthcare facilities impede the learning of student nurses.

In the current study student nurses found that communication was ineffective. This brought frustration among student nurses. According to Rikhotso et al. (2014:5), in-effective communication may be worsened by ethnocentrism. Ethnocentrism is the act of judging another culture based on preconceptions that are found in the values and standards of one's own culture, especially regarding language, behavior, customs, and religion. During interaction, students and clinical staff communicate and set goals which in this case should assist student nurses in achieving their goals of becoming safe and competent nursing practitioners (George, 2014:260). King's goal attainment theory encourages communication between clinical staff and student nurses, where the two parties involved reach agreement and set goals (Gonzalo, 2014). According to the participants of the current study, the parties involved failed to communicate and that lead to frustration and stress for both clinical staff and undergraduate nursing students.

Student nurses were treated badly by clinical staff who disrespected them. Staff members were not prepared to exchange information or guide them. Goal Attainment Theory suggests that staff should be guided in how to communicate effectively with both colleagues and patients (George, 2014:257-258). Nursing staff degraded the students and used offensive language. King's theory refers to this as power being abused in a situation, in this instance, the ward or healthcare facility where students are doing their practical. She also indicates that poor intrapersonal and interpersonal communication skills can affect people's social exchanges, as was the case in this study, where students were too scared to communicate with ward staff (George, 2014:258). The theorist further explains that this is energy exerted in order to avoid chaos (George, 2014:259). Similar results were found by Cunze (2016:68) and Saifan et al. (2015:65), where the students reported that some professional nurses displayed unacceptable behaviour and spoke to students inappropriately, blaming the students in the presence of other staff and patients. This was clearly an abuse of power within a power relationship between the students and the registered nurses. One of the characteristics of effective communication is listening. Listening is responsible nursing practice and requires concentration and mobilisation of all the senses for the perception of verbal and non-verbal messages emitted by each patient (Kourkouta & Papathanasiou, 2014:66). By listening, nurses assess the situation and the problems of the patient. Kourkouta and Papathanasiou (2014:65) reported that patients who are shy or illiterate, are reluctant to seek explanation, therefore the consultation is inadequate and does not lead to the right outcome for the patient. If decision making in which choices are made, regarding activities which can influence the outcome for patients and for student nurses is not done by all parties involved, then goals for both patients and student nurses cannot be attained (King, cited in George, 2014:259). In the current study, it was found that clinical staff were not willing to listen to students or patients, which compromised the quality of patient care. According to the participants, the patients asked questions, but they were ignored by the clinical staff. According to Kourkouta and Papathanasiou (2014:67), good communication improves the quality of care provided to patients. According to O'Daniel and Rosenstein (2008:2-271) and Jooste (2018:229), a lack of communication creates a situation where medical hazards can occur. Owing to poor communication, the patient's life was compromised, as verbalised by one of the participants: *"The physios use these water bottles where the people have to blow in, but they didn't explain to us what is that bottle for, so this was a really bad experience that I went through. I told the people who had the bottles that they must drink that water."* The clinical learning opportunities, clinical guidance and support of these nursing students are

hampered by ineffective communication (Mothiba et al., 2012:202; Rikhotso et al., 2014:e5; Jahanpour et al., 2016:2). An environment where communication is not effective and experiential learning is compromised, makes it difficult for student nurses to attain their learning outcomes and complete the requirements of the programme, as well as attaining their set goals (Jamshidi, 2012:3336; Jamshidi, 2016:4; Jooste, 2017:130).

According to Furnes et al. (2018:1), language competence is a prerequisite for good communication. This study found that student nurses experienced language problems during clinical practice. Language non-proficiency has been one of the limitations of nursing students during clinical practice (Awe, 2014:18; Mwai, 2014:14). Awe (2014:18) defines language non-proficiency as the inability to speak, comprehend, write in and relate to a language which will establish an effective interaction. The participants reported missed learning opportunities owing to a language problem in the wards. It was found that the clinical staff avoided nursing students who could not express themselves in Afrikaans. During clinical practice, ward staff focused only on those students who were able to speak and understand Afrikaans. "Nursing students with a native language, other than that of the majority of their peers, might face an additional challenge when it comes to communication skills". (Furnes et al., 2018:1) Language non-proficiency made the students feel frustrated and isolated. These findings were similar to those of Mwai (2014:14). Language problems can be a barrier to quality patient care. Students reported that they had a problem reading documentation, and during handover and ward rounds, they missed important information as they did not understand the language used by the staff. According to Kourkouta and Papathanasiou (2014:65), quality nursing care is achieved through an interpersonal environment where all sorts of communication skills are valued. King, cited in George (2014:265), agrees with Kourkouta and Papathanasiou (2014:65), as she describes the steps of the nursing process as a system of interrelated actions that if communicated appropriately, will assist students to achieve their goals within the clinical environment. Rikhotso et al. (2014:5) recommended that interpersonal communication skills should be practised and implemented by all nurses throughout the training of students to embrace the cultural diversity of the South African rainbow nation. This will have a therapeutic effect on individuals and on the clinical environment. During clinical practice, one of the skills that students should learn, is communication, therefore it is important for professional nurses, nurse managers and clinical tutors to involve and guide the nursing students, in order for these student nurses to learn and be prepared for the future, to be competent professional nurses who care for diverse patients within society (Rikhotso et al., 2014:5).

In a study done by Neshuku and Amukugo (2015:95), it was found that sometimes poor communication is a stumbling block in student supervision and that cause incompetence of students especially after completion. This study concurs with the findings of this current study.

5.2.2 Theme 2: Teaching and learning support

Clinical teaching is the means by which students learn to apply the theory of nursing, facilitating integration of theoretical knowledge and practical skills with clinical facilities (Siganga, 2013:11; Walker et al, 2014:104; Doyle et al, 2017:27). When students are in clinical settings, they are not in isolation but clinical staff are there to guide them. According to King's theory of goal attainment as cited by George (2014:260), student nurses interact with clinical staff who are in the clinical learning environment, hoping to learn and experience professional cultures and clinical competencies under guidance and supervision of the professional clinical staff (George, 2014:260). It is the duty of a professional nurse to teach and support students while they are in clinical facilities (Jokelainen et al., 2013:61; Flott and Linden, 2016:509). According to Nyelisani (2016:72), professional nurses should not ignore their role of teaching, but also ensure their mentoring role of student nurses. The qualified staff should be willing to supervise, mentor and assess student nurses in order to create clinical environments that are conducive to learning (Quinn, 2000:23; Jooste, 2018:247). Some authors revealed that clinical teaching and learning support is not adequately conducted (Mampunge, 2013:69; Vizcaya-Moreno, 2018:327). This is a similar finding in this research study. In a study done by Vizcaya-Moreno (2018:328), participants reported that the clinical educator role was not clearly defined. According to Jack et al. (2017:4707), clinical staff are seen as relevant role models compared to clinical educators employed by the college.

5.2.2.1 Clinical teaching by ward staff

The reason that student nurses are placed in healthcare facilities is to provide them with opportunities to practise clinical skills, while being guided and supported by well-trained and experienced clinical staff who act as role models (Zenani, 2016:12). During clinical placement, nursing students need all the support they can get from all clinical staff. The staff must balance patient care with added responsibilities of helping student nurses meet their clinical learning objectives. Hence, it is important to have competent clinical staff to facilitate the student's clinical learning experience (Wawire et al., 2014:90). According to the participants of this study, registered nurses should take full responsibility for the training

and experiential learning of student nurses. According to Jack et al. (2017:4707) clinical staff are seen as relevant role models compared to clinical educators employed by the college. According to the above authors, students were not supervised and witnessed poor clinical practice. Jack et al. (2017:4712), stated that continuous exposure to clinical staff, who display poor practices, will result that students will adopt the same bad behaviours, due to poor role modelling of senior staff. It is required of registered nurses to create an environment and learning opportunities that foster the professional growth and improvement of student nurses. Registered nurses should actively engage in the education and training of learners (South African Nursing Council, 2013:6). Stevens (2014:1), in his study, identified that teaching of undergraduate student nurses is the most important function of a professional nurse and other permanent staff in the unit. All personnel, including other professionals, in clinical areas, have a shared responsibility to teach students and to demonstrate procedures to them (Setati & Nkosi, 2017:134). All professional nurses have a moral duty to teach, mentor and supervise all student nurses in their units or wards, so that student nurses can deliver quality and safe care to patients (Muthathi et al., 2017:2). In addition, this professional nurses are responsible to ensure that quality care is given to all patients.

In a study concluded by Anderson et al. (2018:233), professional nurses confessed that they had a responsibility to provide professional development to student nurses and to teach and support them while in their clinical placement. According to these professional nurses, they felt responsible for assisting the next generation to become competent. When students are in clinical placement, registered nurses are expected to teach and guide student nurses in order to verify whether these student nurses perform the clinical practice accurately or not (Mampunge, 2013:63; Anderson et al., 2018:231). This places a great demand on clinical staff (Jokelainen et al., 2013:61; Kaphagawani, 2015:35). In the nursing profession, it is the duty of professional nurses to teach students while they are in healthcare facilities (Siganga, 2013:12; Anderson et al., 2018:231). This study revealed that professional nurses were reluctant to teach and support student nurses because they were always busy with other duties. This was supported by Msiska (2012:131); Houghton et al. (2013:1964); Mampunge (2013:39) and Lee et al. (2018:105), who reported that clinical staff was too busy, or not willing to guide students in the wards. As a result, students learned through their own curiosity by asking and following doctors during ward rounds. In a study by Setati and Nkosi (2017:135), the participants reported that some professional nurses were less interested in student nurses and had nothing to do with them complaining

about the busy unit and that professional nurses were tired and could not show student nurses anything.

Literature revealed that a lack of time in the ward and staff being constantly busy, hinder the teaching and learning of student nurses (Houghton et al., 2013:1964; Neshuku & Amukugo, 2015:89). The findings of this study contradict the findings of Bisholt et al. (2014:307), who indicated that in Sweden, student nurses received teaching and learning support from clinical staff during clinical practice. In the clinical areas there are registered nurses who care for students, who offer guidance and support to students, while there are some registered nurses just telling the students to go and perform a certain procedure so that she/he will come and see later but then never turn up (Neshuku & Amukugo, 2015:92). According to Mažionienė et al. (2018:665), student nurses supervised by registered nurses, during clinical practice, felt at ease and the atmosphere in the unit was positive. Students felt comfortable going to the ward at the start of a shift and clinic staff were easy to approach.

The current study revealed that the clinical areas where students were placed, were different. In some areas clinical staff were willing to teach and support the students. The above findings were consistent with those of Magnani et al. (2014:59) and Tyanti and Seekoe (2015:56), who reported that in some units the teaching and learning of a student nurse were very important and some qualified nurses and other healthcare providers, such as doctors, were willing to teach and support students in the clinical practice. This study revealed that students were motivated when professional nurses asked them questions. They felt that their learning was enhanced. According to Lekalakala-Mokgele and Caka (2015:1), students feel safe to practice when they are supported by clinical staff. However, this finding is in contrast with the findings of Arkan et al. (2018: 130). In the study by Arkan et al., students stated that their learning was affected negatively, since the instructors asked too many questions. In a study done by Rikhotso et al. (2014: e2), clinical professional nurses reported that providing guidance and support for student nurses was an extra workload already exacerbated by understaffing. Neshuku & Amukugo, (2015:93) reported that registered nurses were not interested to help student nurses to learn but they were only interested in manpower to do transport duties. In a study by Anderson et al. (2018:233), participants reported that teaching and supporting student nurses were considered to be an added, something in addition to the workload.

In some instances, student nurses were the reason the clinical staff were unwilling to teach students because of the students' behaviour during clinical placement (Msiska et al.,

2014:38). According to Setati and Nkosi (2017:135) negative behavior of student nurses was the reason that professional nurses were not willing to teach student nurses. Papastavrou et al. (2016:7) concur with Msiska, stating that for the student nurse to learn, depends on that students' preparedness, readiness and willingness to learn. In their study Neshuku and Amukugo (2015:90), reported that the nursing students were not interested in practicing nursing or even in their learning. Student nurses had negative attitudes, not interested in what professional nurses in the ward were doing. Hence, at the end of their placement time, they ended up having learnt nothing and remains incompetent. According to Neshuku & Amukugo (2015:91), one of the things that made registered nurses unwilling to assist the student nurses, was that these registered nurses did not undergo the same training as the student nurses, and that made it difficult for clinical staff to help student nurses allocated to their wards. Effective clinical teaching requires competent clinical staff, hence it is important for the professional nurses to maintain their clinical competence to assist in development of nursing students and to provide supervision in clinical settings (Mutair, 2015:3). Mutair (2015:3) concurs with Neshuku & Amukugo (2015:91) stating that professional nurses in the clinical setting should maintain clinical competence in order to assist student nurses in their development of knowledge and skills and provide expert supervision in the clinical setting. According to Mutair (2015:3), clinical staff in placement areas must set an example. All stake holders should know that the quality of student learning is not only depended on the type of clinical experience, but it is also depended on characteristics and skills of the professional nurse in the ward, who facilitate that learning.

5.2.2.2 Clinical support from clinical educators/mentors

Clinical educators have a big influence on student nurses' learning. The character and attitude of a clinical educator plays a big role in the development of professional nurses who are knowledgeable and skilful within a health care system. Clinical educators have a duty to produce professional nurses who will be able to deliver safe quality nursing services to patients, families, and communities, professional nurses who will attain, maintain and recover optimal health (Ismail et al., 2016:96). According to Mutair et al. (2015:3), it is important for clinical educators to act as role models, that is set an example in clinical settings because student nurses' learning is not only dependent on the type of clinical experience but also on the characteristics and skills of the educator who facilitates that learning. It is the duty of nurse educators to develop the student nurse's cognitive, psychomotor and affective skills and she/he achieves this through clinical facilitation (SANC, 2014:3).

Mentoring is core and the only means of teaching and socialising student nurses in the profession (Setati & Nkosi, 2017:135). According to Setati and Nkosi (2017), good mentoring is a means to narrow the gap between practice and theory. There are many discrepancies found in practice between what is taught at college and what is happening in the actual practice environment (Setati & Nkosi, 2017:136). In a study by Dimitriadou et al. (2015:239), students verbalised that clinical educators were the most important people who helped them to understand the fundamental concept of practice. Froneman et al. (2016:1), state that clinical educators should show concern for students, act as confidants and role models, and be mentors with caring attitudes. Caring educators contribute to students' capacity to overcome vulnerability and clinical environmental problems. It is important for the clinical educators to be an expert in their subject matter. According to Mutair (2015:3), these clinical educators should have a broad knowledge based in both theory and practice, in order to assist and guide the students to connect their theoretical knowledge that they have learned in the classroom with that in the practical environment. Clinical educators should share practical knowledge with undergraduate student nurses. It is the duty of the clinical mentor to teach and assist the student nurse to integrate theory into practice (Jokelainen et al., 2013:61; Wawire et al., 2014:90). Mutair (2015:3) concurs with the above authors stating that applying theoretic knowledge and skills in the clinical area, is a major task for the clinical educator. In a study by Neshuku and Amukugo (2015:91), student nurses felt that clinical educators need to be available in the clinical practice areas because clinical educators are the key component towards the effective clinical placement of nursing students. Literature revealed that in South Arabia, the number of clinical educators in clinical areas, are less than what is required, compared to the number of students (Mutair, 2015:2).

In the current study, the student nurses reported that the support they received from the clinical educators was very poor. Msiska (2012:119); Neshuku and Amukugo (2015:90), reflect similar findings, in that clinical educators failed to support student nurses in their clinical placements. Their visits to clinical areas were quite infrequent. In contrast with Dimitriadou et al. (2015:239), who reported that student nurses were happy with the support they received from their clinical educators, according to these students, the clinical educators helped them to gain a sense of professional identity and meet their individual needs. This study also revealed that owing to the large number of students, clinical mentors only came for clinical evaluations. The current study concurs with Mampunge (2013:69); Neshuku and Amukugo (2015:91), who state that lecturers were not visible in clinical placement settings to support student nurses during clinical exposure, and they only came

for clinical evaluations. This had a negative impact on the learning experience of these student nurses. According to the participants, inappropriate behaviour was evident when clinical educators dealt with issues that affected students. However, some of the participants appreciated their mentors (clinical educators), saying that they played an important role in their learning. Froneman et al. (2016:1) concur with this: educators can have a positive effect on students' behaviour which could have a positive effect on their success in life in the future and in the long term.

According to the participants, there is a difference between practising in simulation laboratories and practising in healthcare facilities. When they are in healthcare facilities, they are more nervous, as they are confronted with real patients, unlike in the laboratories. Therefore, it is important for the clinical educators to accompany the student nurses when in clinical practice in order to support them. This was consistent with the findings of Kaphagawani (2015:206) and Nyelisani (2016:69), who found that students enjoyed being supervised by their clinical educators, so that they could put into practice what they had learned in the classroom (simulation laboratory). Students also develop confidence if the clinical educator is nearby to observe, guide and support. In a study by Joubert and De Villiers (2015:4), it was revealed that the students appreciated the presence of clinical educators and students felt reassured because clinical educators were with them. According to Mutair (2015:4), student learning is enhanced if clinical educators have unconditional positive regard for their students. Clinical educators have to be sensitive to students' feelings and problems and enhance the students' ability to learn (Mutair, 2015:4). This study revealed that the clinical educator plays an important role in the teaching and learning of a student nurse. These findings concur with those of Nabolsi et al. (2012:5852) and Phuma-Ngaiyaye et al. (2017:168), who found that clinical educators have a major impact on students' learning experiences. According to Burton and Ormrod (2011:192); Mutair (2015:3), the role of the clinical educator is to facilitate learning, create an environment that is conducive to the learning and practice of the student nurse, and to establish an effective working relationship. In contrast, the current study revealed that the clinical educators failed to execute their role as clinical educators. Most of the participants verbalised the unavailability of the clinical educators in the healthcare settings. This affected their clinical learning experience negatively. These findings are similar to those of Nabolsi et al. (2012:5853); Mampunge (2013:38) and Joubert and De Villiers (2015:4). This study, however, contradicts the findings of Phuma-Ngaiyaye et al. (2017:168), who found that in Malawi, the clinical educators supported and facilitated the students' learning. These educators also identified student learning opportunities. This study revealed that owing to

the poor support of clinical educators in the placement areas, students became vulnerable. These results are consistent with those of Baraz et al. (2015:9), who stated that owing to insufficient support of the instructor at the bedside, students had become vulnerable and were less confident and demotivated to learn. Froneman et al. (2016:7) concur that the ideal student–teacher relationship results from the nurse educator’s visit to the clinical area to see how students are progressing. By doing this, clinical educators show an interest in students and they teach students and assist them with problems, even if the ward staff were available to support the students (Froneman et al., 2016:7). In a study by Muthathi et al. (2017: 6), all year levels of nursing students verbalized the need and importance for the support and supervision by nurse educators in all clinical areas.

5.2.2.3 Peer support and learning

The current study revealed that the availability of other students lessens the amount of stress experienced by students and increases learning. Students shared in the groups that they value the support of their peers when they are in clinical practice. The support they get from one another makes their tasks easier to achieve. These findings are consistent with previous research (Msiska, 2012:149; Potgieter, 2012:7; Serçekus & Başkale, 2016:137). Students’ level of self-efficacy improves when students work with their peers (Pålsson et al., 2017:86; Arkan et al., 2018:131). This study concurs with Houghton et al. (2013:1966); Potgieter (2012:7) and Kaphagawani (2015:172) who noted that students found the presence of other students beneficial for learning, as it provided an alternative type of support. The students also said that they supported one another when the clinical educators and clinical staff disappeared and were absent. However, peer support may have a negative impact on students’ learning (Houghton, 2014:2369). According to Houghton (2014:2369), even though peer support is needed, it can have a negative impact on students’ learning, therefore it must be monitored. Large numbers of students in one placement area, can lead to student forming ‘parallel communities, which can isolate students from potential supportive relationships in the placement areas.

5.2.3 Theme 3: Learning opportunities

The main objectives of clinical placement are to provide student nurses with meaningful learning opportunities according to their level of training. Placement of student nurses is done to ensure that on completion of the programme, they are able to function effectively (SANC, 2013:2; Brand, 2016:1). The South African Nursing Council (SANC, 2013:2), describes clinical learning opportunities as the variety of learning experiences obtained in

clinical facilities or other experiential learning areas made available for students to master clinical practice. A learning opportunity is any event or activity that occurs in a placement area that a student might learn something from, either by getting involved (that is a hands-on situation) or by observing (Elcock & Sharples, 2011:33). Provision of learning opportunities is important for facilitating student learning and implementation of skills (Houghton et al., 2013:1966; Muthathi et al., 2017:1). According to Nyelisani (2016:84), it is the duty of the nurse educator and professional nurse in the placement area to provide the student with learning opportunities. The findings of this study revealed that most of the students experienced a lack of clinical learning opportunities in the clinical facilities. This resulted in students spending most of their time doing routine work in the hospital. Hence, the students did not achieve their programme outcomes. The results of the current study are similar to those of Nabolsi et al. (2012:5851) and Mothobi (2017:85), who stated that in some clinical settings there was a lack of training opportunities owing to a large number of multi-professional students like medical students. Houghton et al. (2013:1966) and Labeeb et al. (2017:145) identified the provision of learning opportunities as important for facilitating student nurse learning and implementation of clinical skills. According to Kaphagawani (2015:183), increased workloads compromise learning opportunities in clinical practice. Participants in this study complained of busy wards which restricted student nurses' opportunities for learning. These findings contradict those of Labeeb et al. (2017:145), where students felt that busy wards gave them excellent opportunities to practise tasks repeatedly. The participants in this study felt that some wards or units provided more learning opportunities than others. This is consistent with the results of Mamaghani et al. (2016:219), who found that emergency and intensive care units provided more educational opportunities.

5.2.3.1 Involvement of students in teaching and learning activities

The fundamental of King's Theory of Goal attainment is that clients must be involved in their clinical learning (Caceres, 2015:154). Learning takes place when students are provided with opportunities to practise by doing (Kaphagawani & Useh, 2013:183; Kaphagawani, 2015:212). During their training, student nurses are placed in a clinical environment to obtain hands-on work experience (Nabolsi et al, 2012:5851; Wan & Gim, 2014:10; Ali & Ali, 2017:74; Mothobi, 2017:48). Students view their clinical experience as positive when they receive hands-on training (Nabolsi, 2012:5852; Murray, 2018:1). According to Ali and Ali (2017:75), effective clinical learning requires engaging student nurses in hospital ward duties. In a study done in Turkey, nursing students reported that

they learned more and felt more motivated when clinical staff involved them in various practices (Arkan et al., 2018:129). In a study done by Stevens (2017:77), registered nurses deliberately created learning opportunities for student nurses. These student nurses were delegated to take charge of the situation. This served as a confidence booster for the students. One of the major systems of goal attainment theory, is the personal system (George, 2014:260). In her theory, King see every person as a unique person, therefore each individual should be treated as a personal system which includes the dimension of perception, self, growth and development, self-esteem and learning. Literature revealed that student nurses like to be treated as individuals who can be involved in decision making (Stevens, 2014:58; Labeeb et al. 2017:145). Growth and development is the concept of a personal system (Adib-Hajbaghery & Tahmouresi, 2018:142). During clinical placement, the students, clinical staff and the mentors all set goals towards quality patient care, which in the case of this study, is the development of a competent safe practitioner. The findings of this study contradicted with King' Theory of Goal attainment, according to the participants of this study the students were not involved in planning and setting of goals. Student nurse's willingness to participate in decision making is important to goal attainment.

When clinical staff see student nurses as individuals with insight or perception, it is easy for the staff to involve the nursing students in practical activities and that facilitates goal attainment which in this case, is the effective learning of the student nurse leading to clinical competence. According to Stevens (2014:58), students felt happy and excited for being actively involved in nursing activities. The findings of the current study support those of Labeeb et al. (2017:145) which revealed that student nurses appreciated learning experiences, noting they were more useful than just learning the theory. Doing and practising repeatedly, allowed them to become skilful and to obtain a clear understanding of the procedure. This study reveals that during clinical placement, students like being involved with challenging activities. The current study is echoed by Mothiba et al. (2012:200), and Niederriter et al. (2017:4), who stated that student nurses enjoy being given challenging activities during clinical practice. In a study done by Ali and Ali (2017:75), at the Faculty of Nursing at Sohag University in Egypt, student nurses had little opportunity for involvement in ward activities in hospitals. This study revealed that clinical placement areas were not the same. In some areas, students were more involved in clinical activities. This is supported by Brand (2016:1), who concurs that no two placement settings are easily comparable.

5.2.3.2 Clinical allocation

It was reported by the study participants that the duration in placement areas was too short. This short length of stay affected students' learning negatively. Similarly, Killam and Heerschap (2013:689), Kaphagawani (2015:157), Truong (2015:90), Lee et al. (2018:107) and Silva et al. (2018:178), argued that short clinical rotations limit and reduce opportunities to learn. In contrast, Gilmour et al. (2013: e21) revealed that the quality of student learning in the clinical environment depends on the effectiveness of the clinical educator to whom the student is allocated, rather than the length of exposure. In a study done in Vietnam, students reported their need to practise longer in the clinical settings as the learning opportunities were insufficient for their learning needs (Truong, 2015:91). According to Silva et al. (2018:178), students were unable to complete their objectives within the allocated time due to the short stay in clinical practice. In contrast, Du Toit (2013:50) and Stevens (2017:65), are of the opinion that learning opportunities in clinical placement areas are sufficient. According to Du Toit (2013:50) and Stevens (2017:65), all registered nurses should make use of every possible opportunity to teach and demonstrate to the undergraduate student nurses allocated in their respective sections of the health facility. According to Motsilanyane (2015:20), clinical placement is done according to the expected outcomes for the level of training. It should be planned in such a way that the clinical skills performed during the placement are aligned with the theoretical content. In contrast with the study done by Motsilanyane (2015:20), the current study reported that nursing students were removed from their placement areas where they were allocated to fulfil their objectives, owing to staff shortages. Hence, they could not complete their prescribed objectives. This is what one of the students had to say: *"We are being forced to go and work in different wards when we are allocated to a specific ward. The same happens on night shift. Someone doesn't show up and you have to go and work. You don't owe Medical hours but you have to go and work in the Medical ward. We are trying to learn but while we have to start in the Medical ward they are taking us out and put us in the surgical ward because that is where they want us to start. That is the reality we are facing. This should really be addressed at a managerial level"* (P12-y3-Fg3).

One of the participants reported that longer periods in the ward made the student feel like one of the staff members and that boosted the student's confidence. This is what the student had to say. *"I worked in a ward for a month and not the normal fourteen days. I became one of the staff, I felt that I knew where everything was, people came and I knew*

exactly what to do.” These comments were similar to Lee et al. (2018:107), who found that longer durations were beneficial for the building of positive relationships between nursing staff and nursing students. Levette -Jones et al. (2008), cited by Lee et al. (2018:107), reported that longer placement in a ward helps the nursing student gain a greater sense of belonging. However, Brammer (2008), cited by Lee et al. (2018:107), argued that it is not the length of stay in the clinical placement that guarantees positive interpersonal relationships between clinical staff and nursing students, but rather students’ positive learning experiences. Even with longer clinical placements, if the quality of clinical education or the quality of interpersonal relationships cannot be ensured, student nurses could still have clinical experiences whereby their learning is impaired (Lee et al. 2018:107).

5.2.3.3 Practical opportunities

This study revealed that students were not exposed to clinical practice, even though they were placed in clinical settings. Participants expected to practise clinical skills in clinical settings in order to become competent and skilful practitioners. Gaberson et al. (2015:10) argue that if students are placed in clinical settings, they need to practise the skills they are learning before their performance is evaluated to determine their competence. It was found that students were not exposed to clinical practice, even though they were placed in clinical settings. This is consistent with the findings of Vos (2013:51) and Kaphagawani (2015:162), who reported that students did not gain much exposure in the clinical areas. Kaphagawani (2015:162) reported that clinical staff preferred to do procedures themselves, to save time, instead of leaving it to students to practice. This results in a lack of practice for some skills for the students. In such instances students are denied practical opportunities to learn new skills or to apply their skills previously practiced and learnt. The current study revealed that clinical staff denied the students opportunities to practise what they had learned, in the nursing school. These findings are also consistent with those of Mampunge (2015:43), who explored the experiences of nursing students in the Eastern Cape while in clinical settings. It was found that ward sisters denied students the opportunity to practise ward management in clinical settings. Similarly, Labeeb et al. (2017:150), in a study completed in Iran, revealed that students were not allowed to touch the patients or any equipment. These disallowed practical opportunities for nursing students. In contrast, with the aforementioned studies, Setumo (2013:73), and Stevens (2017:77), in their findings, revealed that students were exposed to practical opportunities. Sometimes students were even allowed to take charge of ward rounds.

During the focus-group discussions of this study, students said that they could not practise clinical skills efficiently owing to the workload in the wards. They were regarded as part of the workforce in the wards and were scheduled as such. Their student status was overlooked. These findings are similar to those of Pili and Pili (2013:70), and Kaphagawani (2015:161), where students reported that they did not do anything educative owing to the clinic workload, and which resulted in insufficient learning opportunities. Students also reported that they were allocated to wards in large numbers, which limited their practical opportunities and learning experiences. King, cited in George (2014:257), believes that interpersonal relationships are formed by people interacting with one another. However, she described these relationships as complex, when there are a number of people that have to interact with one another. This sheds light on why students complained about the quality of clinical education learning during their practical experiences. Ratios of students to staff or mentors in the wards were imbalanced, hence the frustration for both students and staff members.

Ahmadi et al. (2018:66), studied student experiences of learning clinical skills in Iran and found that students had little opportunity to practise clinical skills because of the large number of students placed in the same ward. This result concurs with the outcome of this study. Luhanga (2017:94), in a study done in Canada, also stated that students missed practical opportunities because of the large numbers of students placed in one unit.

5.2.4 Theme 4: Inability to achieve objectives

Mogale (2011:69) argued that students are placed in the clinical setting for the purpose of learning, so that they cover their learning outcomes according to the skills to be learned in that particular unit. According to Rikhotso (2010:52) and Kaphagawani (2015:211), students were expected to be placed in placement areas to accomplish their learning objectives. When students were in clinical areas, they were expected to do routine jobs, even if those jobs were not listed in their learning objectives. Sometimes students were removed from their placement areas. This made it difficult for them to achieve their learning objectives. Kaphagawani (2015:160), reported that sometimes students were placed where opportunities were lacking to fulfil their objectives. Owing to workloads and staff shortages, students were forced to perform duties beyond their scope of practice and these hindered students from accomplishing their learning outcomes (Letswalo & Peu, 2015:360). Educators should be available while students are in clinical placement to ensure that students get the best supervision, guidance and mentoring. This would ensure they achieve their objectives (Nikkinen & Ngoc Le, 2016:3; Gilmour et al., 2013: e21).

5.2.4.1 Inappropriate delegation of students.

Professional nurses are supposed to delegate activities/duties to nursing students according to their year of training (Letswalo & Peu, 2015:360). According to Meyer (2011: 228), cited by Mathebula (2016:94), skills, experience, knowledge, scope of practice, professional maturity, and personal maturity, should be analysed before delegation. This study revealed that students were not delegated according to their year of study and that hindered their learning. All tasks were delegated to them, whether they had completed the theory or not, and their year of study was not considered during delegation. These findings are consistent with those of Mampunge (2013:43), Setumo (2013:73), Mothokoa (2015:73), and Zenani (2016:70), who found that students were delegated duties which were not suitable for their level of training or according to their clinical learning objectives set out for their year of study. Setumo (2013:71), discovered in her study in the Limpopo province that despite the fact that nursing colleges provide the health facilities where students are placed for their clinical practice experience, with learning objectives prior to the placement, those learning objectives were not utilised when the wards' in-service training programmes were planned. The objectives were not considered before delegation of students. In contrast with this study, Mathebula (2016:94); Setati (2013:49), and Setati and Nkosi (2017:133), found that student nurses' duties were delegated to students according to their clinical learning objectives. Participants reported that clinical staff did not want the students to grow and develop. Vos (2013:61), agreed with these findings, stating that these young people were not regarded as students who needed development and growth in order to become competent. The students were also worried about their competence and their future as professional nurses. This is what one of the students had to say: *"The amount that we should learn vs the amount that we actually learn is so little that by the end, when we graduate, we are malnourished students or professionals. For example, we, or I, had to fight with Operational Managers and Sisters in charge to allocate me to the duties that I am meant to do to be competent at the end of every year. Some of my books have not even been completed yet ..."* (P14-y3-Fg3). Vos (2013:61), related in a similar study, that students were concerned about the difficulties they might face after completion of their training.

5.2.4.2 Shortage of staff in clinical settings

According to Mothiba (2017:78), students reported that they could not reach their objectives, as they were regarded as a work force. Students were unable to learn what they were supposed to learn because they were doing the work of permanent staff

members. This was similar to the findings of Dinmohammadi et al. (2016:33), who stated that students were assigned to do clinical staff work to reduce their workload. This resulted in students not reaching their learning objectives. According to the participants, they were placed in specific wards to accomplish their learning objectives, but owing to the shortage of staff, they were sometimes removed from those areas to other wards. According to Dinmohammadi et al. (2016:33), clinical placement was not fruitful because students just had to do routine and repetitive jobs to reduce the staff's workload. Owing to the shortage of clinic staff students were ignored and unsupported, being used as an "extra pair of hand" and the students' supernumerary status ignored (Jack et al, 2018:929). In a study by Jack et al (2018:932), student nurses verbalized that they were counted as ward staff and that led to bad results on their ability to learn and because of that, students failed to meet their placement objectives. According to Jack et al. (2018), if students are expected to help out with ward routine, it can overshadow the fact that students need to learn specific things on each placement.

5.2.5 Theme 5: Enjoyment moments

According to the participants in this study, there were times when they enjoyed being in the clinical settings. What these students enjoyed most, was taking care of patients and seeing them recover. This motivated them positively. Henderson and Eaton (2013:199), argued that acknowledgement and recognition of others should be continuous in order to sustain interest of others to learn. Findings of the current study revealed that students liked being appreciated and accepted by clinical staff and the rest of the team in the wards or the units.

5.2.5.1 Seeing patients recover

In a study done by Nyelisani (2016:60), students reported that seeing patients recover and go back home, made the students happy. This study revealed that nursing students felt good when their patients recovered. According to the informants, helping their patients gave them happiness. These findings are similar to those of Nabolsi et al. (2012:5851) and Nyelisani (2016:60), who stated that students felt happy and motivated when they provided complete care to their patients. Participants of this study reported that caring for the patient and seeing their condition improving, was satisfying for the students. This is what the student had to say: *"My biggest experience was also a lady at my first placement who was dying. She didn't even talk to her children. They also gave up on her because she didn't even look at them. Her condition was just deteriorating, they even moved her to an isolated*

room so that she can be alone if she dies. (YENE!) (EXCITED also clapping hands)"That woman recovered, she was even shouting at us now but the thing is I didn't took that personal I loved it because I know where she came from. Yes she was skulling (shouting) the nurses. Now she was shouting at us, but I didn't care, because I was just astounded that she had recovered and I knew I was part of that because I did her physical exercises with her, I helped her to mobilise her for washing, I was fixing her, checking for abnormalities all the time, so I was part of that team who caused her to now shout at us. That was very nice for me" (P34-y2-Fg8). These findings are consistent with Nyelisani (2016:61), who reported that students felt excited to be part of the team taking care of the patients, from the time they were admitted in a helpless state and watching them improving and being discharged, was fulfilling for the students. Literature revealed that students feel good for being advocates for their patients (Ndaba, 2013:57; Nyelisani, 2016:60). King (in George, 2014:262), refers to this as transactions between human beings. These transactions lead to exchanges that include observable behaviours that seek to reach their goals. Students, witnessing the progress and recovery of their patients, feel worthy and happy that they are working to attain their goals of becoming skilful and competent nursing practitioners. Hence, goal attainment leads to effective nursing care (George, 2014:262).

5.2.5.2 Being accepted as a student

Literature revealed that when students are in the clinical setting, it is important that students fit in and are accepted as part of the group. If the students are welcomed and treated as members of the clinical staff, it will enhance the students' learning (Jacobs et al., 2013:11; Pili & Pili, 2013:70; Lekalakala-Mokgele & Caka, 2015:5). According to Lekalakala-Mokgele & Caka (2015:5), a welcoming environment is a source of active participation and provides learning opportunities for students. Participants of this study reported that they enjoyed being orientated and made to feel welcome and accepted in some wards. In a study by Lekalakala-Mokgele and Caka (2015:1), it was found that students felt a sense of belonging when clinical staff showed an interest in them and welcomed them. Student nurses expect to be accepted when they are in placement areas. If students cannot gain acceptance from the clinical staff, these students may lose confidence that is required to be a professional nurse and it would make them feel incompetent (Hsu et al., 2018:439). Clements et al (2016:23), in their study found that if the students are welcomed and accepted by clinical staff and mentors or feeling valued and having positive interaction with ward staff, it will contribute to the improvement of the student nurses' motivation to proceed in their profession. It will also increase the students' commitment.

5.2.5.3 Being appreciated

The results of this study revealed that student nurses felt good and encouraged when they were appreciated. Acknowledgement and recognition should be done continuously to sustain the interest of the learner (Henderson and Eaton, 2013:199; Jooste, 2018:162). This can be achieved through a simple routine, such as thanking all staff and students at the end of the shift (Henderson & Eaton, 2013:199; Jooste, 2018:162). According to Jooste (2018:162), it is the duty of the team leader to appreciate the students and let them know that she is grateful of what the student nurses have done. The current study revealed that the students enjoy being appreciated by patients. The following quote confirms that: *She was the nicest patient I had ever seen. We talked every day, and she wants to help you, and if you did something small for her, like just giving her a glass of water, she would say, thank you, I appreciate it. That was very nice to work there for a week.*" (P35-y2-Fg8) According to Labeeb et al. (2017:148), students feel happy when patients acknowledge their work. In a study by Mukumbang and Adejumo (2014:6) in the Western Cape, it was found that patients appreciated the work of undergraduate nurses and that made the nursing students felt valued. Nyelisani (2016:60) concur with Mukumbang and Adejumo stating that students appreciate when patients thank them for what they have done. This makes the student feel valued and appreciated. The implementation of all the activities (doctors' orders and orders from the extended health team), means that the end goals of the transaction between patient and nurse were attained (King, cited in George, 2014:266), hence the nurse is satisfied and feels appreciated. Furthermore, student nurses should be guided towards decision making and the implementation of nursing plans for patients, in order for goal attainment to materialise (George, 2014:257-268).

5.2.6 Theme 6: Challenges

Moonaghi et al. (2015:1) and (Kaphagawani (2015:34) describe clinical education as a complex and dynamic process in which students acquire experience and apply knowledge in practice. It is this complexity that causes students to encounter many challenges while in placement areas. According to Nikkinen and Ngoc Le (2016: II), during clinical placement in health care settings, a lot can happen and hinder the learning performance of students. According to Moonaghi et al. (2015:2) and Kaphagawani (2015:34), challenges and limitations in the clinical setting can reduce the efficacy of clinical education. Jamshidi (2016:2) supports this, stating that challenges in the clinical environment can prevent student nurses from effective learning and growth. Understanding these challenges will help the faculty to use strategies that will improve clinical education (Kaphagawani

2015:34; Jamshidi, 2016:2). Most participants complained of challenges while in clinical practice. In a study done in Iran, it was reported that student nurses faced many challenges in placement settings and these affected their learning negatively (Jamshidi, 2016:1). All challenges identified in this study affected students' learning in the clinical setting negatively.

5.2.6.1 Integration of theory and practice

According to Motsilanyane (2015:78), nursing education consists of both theoretical and practical components. The theory forms the foundation of the learning that the nursing students have to apply in the clinical setting. Students are placed in clinical settings in order to correlate theory with practice (Tiwaken et al., 2015:67). Literature revealed a gap in integrating theory with practice. This has been a problem for a long time in nursing education (Mabuda et al., 2008:23; Kaphagawani & Useh, 2013:182; Zenani, 2016:43; Mothobi, 2017:80). According to Kaphagawani (2015:23) and Kaphagawani and Useh (2018:108), the theory–practice gap is the discrepancy between what has been learned in the classroom setting and what is practised in the clinical setting. According to the participants in this study, there were discrepancies between what they were taught and what they learned in college and what was practised in the clinical settings. Carelse and Dykes (2013:166); Tang and Chan (2019:6) describe integration of theory and practice as the process whereby students' knowledge, values, and skills learned in the classroom, are brought together. Participants in this study were disappointed when they arrived at the clinical settings because they expected to put into practice what they had learned in the classroom. Students were disappointed as it was not as expected. They found the procedures were done differently from what they had learned in the classroom and in the assimilation laboratories. Similar results were found by Kaphagawani (2015:152), in Malawi. This author reported that when students reached the clinical settings, procedures were done differently from what they had learned at college. This study revealed that there were conflicting practices among clinical staff. One sister would tell the student something, and the other would say something different, resulting in confusion and frustration among the students. These findings concur with those of Kaphagawani and Useh (2013:182); Kaphagawani (2015:152) that conflicting practices between the ideal nursing taught and that practised in clinical settings, result in students being confused and anxious. This could also cause the break down in forming relationships and good communication, as King's theory (in George, 2014) demands good communication skills in order to maintain good interrelationships. Participants in this study reported that clinical staff were task oriented

and did not care for patients according to their needs (as they had been taught before being placed in these clinical settings). These findings were similar to those of Zenani (2016:47), where the participants reported that the care provided to patients by clinical staff, was task orientated and did not resemble the comprehensively taught skills and embedded knowledge obtained before they entered the clinical setting. This study revealed that participants were confronted with theory–practice gaps which hindered their clinical learning. These findings support those of Jahanpour et al. (2016:2), who reported that students in Iran complained of theory gaps in practice which left them confused about how to do the procedures.

5.2.6.2 Anxiety

Sun et al. (2016:22) describe anxiety as a feeling of fear, uneasiness and uncertainty. According to these authors, anxiety is usually accompanied by negative emotions such as feeling uncomfortable or unhappy (Sun et al., 2016:22). According to Walker et al. (2014:104), clinical placement is one of the most stressful environments for student nurses. This study revealed that most of the participants were stressed during clinical practice. Some of the participants were anxious because they were dealing with patients' lives. They feared something might go wrong and they could kill the patient. These findings correspond with those of Sun et al. (2016:25), which showed that student nurses in their clinical practice worried about harming patients. The participants reported that they felt anxious because they did not know if they would be able to do what was expected of them. These findings are consistent with those of Dinmohammadi et al. (2016:34), who reported that students were worried about being faced with patients' needs they could not deal with and feared making mistakes that could harm patients. The current study revealed that reality causes anxiety as students are dealing with real-life situations and not mannequins in simulation laboratories. According to King (in George, 2014), this causes a breakdown in interpersonal relationships, which will affect these students negatively and will not assist them to reach their goals. This study supports that of Houghton et al. (2013:1966); Ahmadi et al. (2018:68), who found that the reality of practice could cause anxiety for students and hinder implementation of skills in practice.

5.2.6.3 Students were left alone

The participants in this study reported that students were left alone to do work without supervision. This put a lot of pressure on students since they were frightened of making errors. The literature reveals that on many occasions, students are left alone to struggle

with unfamiliar tasks, not included during their clinical learning experience (Killam & Heerschap, 2013:688; Msiska et al., 2014:40; Walker et al., 2014:107). Msiska et al. (2014:40) concur with these findings, stating that leaving students unattended with patients can put the patients' lives at risk. Some literature reported that if students are left alone in placement areas with little support from clinical staff, it impacts negatively on their confidence (Shoqirat and Abu-Qamar, 2013:55; Kaphagawani & Useh, 2018:106). This study revealed that because these students were ignored, they also lost confidence in nursing. Some of the participants reported that clinical staff wanted to have nothing to do with them. Walker et al. (2014:106), concur with these findings, stating that clinic staff had no interest in the students and that made students feel that they were a burden to ward staff. According to Killam and Heerschap (2013:688), it is difficult for students to overcome this isolation, if clinic staff favour other groups of nurses. Busy wards were one of the factors identified as the cause of students being left alone (Neshuku & Amukugo, 2015:89). Atakro et al. (2019:6), in their study revealed that the generation gap between the undergraduate nursing students and clinical staff also lead to isolation of student nurses. This generation gap brought clashes between the different generations, as these student nurses come with new ideas in the clinical areas.

5.2.6.4 Violence

Engelbrecht et al. (2017:8494), reported that most undergraduate nursing students in South Africa experience intra-professional violence in the clinical environment. Tee et al. (2016:30), define workplace violence as a violent act directed towards workers. It can include physical, psychological or verbal behaviour. According to Webster et al. (2016:40), violence represents negative interactions involving any form of bullying, abuse, harassment or unwanted behaviour that can cause the recipient to feel unwanted, threatened or upset. Similar negative experiences among students can have a direct impact on the development of their future professional skills and competencies as nurse practitioners (Mamaghani et al., 2018:221). Violence is now more common in nursing and causes victims to suffer work-based stress that can affect the individuals and the quality of care given to patients (Tee et al., 2016:30; Engelbrecht et al., 2017:8495). According to Engelbrecht et al. (2017:8494), during clinical placement undergraduate nursing students are vulnerable to intra-professional violence. Participants in this study experienced different types of abuse. Some reported that they were sexually abused by support staff who included security, clerks and other administrative staff. Students were also verbally and emotionally abused by the clinical staff and the patients placed in their care. Most of

these participants were humiliated, belittled and talked about in a derogatory manner behind their backs. Findings of this study are consistent with those of Webster et al. (2016:44) where students were bullied, yelled at and belittled. Instances of verbal abuse included “being put down”, “being humiliated”, “having sarcastic remarks made” and “being talked about behind your back”. These findings are supported by Tee et al. (2016:33) and Mamaghani et al. (2018:221), who reported that students were exposed to bullying and workplace violence. A study done by Tee et al. (2016:35), in the UK showed that a high number of student nurses experience bullying and harassment while in clinical settings. Participants in this study reported that clinical staff were hostile, rude and verbally abusive. These findings are similar to those of Abulaban (2013:10) in Palestine and of Vuolo (2017:107) in the United Kingdom, where students reported being vulnerable, as they were bullied and belittled by clinical staff.

5.2.6.5 Congestion of students

Participants in this study reported that large numbers of students in one placement area limited their learning opportunities. Similar findings were also found in the study of Ahmadi et al. (2018:66), where participants reported that they had problems in accessing clinical learning opportunities owing to the high numbers of students in the clinical practice areas. The findings of this study revealed that because of a high number of students in one clinical area, students had to compete for limited procedures as expressed by one of the participants: *“I haven’t had a good experience in hospital. It’s like we had two types of students – the Pen students and us. I was about to do a procedure on one of the patients when another student said, ‘No, that’s my patient”* (p19-y3-Fg4). These finding concur with those of Ahmadi et al. (2018:66) who reported that nursing students were competing with obstetric residents, who also needed experience conducting births. Chuan and Barnett (2012:195); Kaphagawani and Useh (2018:108) concur with the aforementioned findings, as they reported that there were too many students on the ward competing to do procedures, which hindered the student nurses’ learning. Literature revealed that large numbers of students in clinical settings affect the learning of student nurses negatively (Mampunge & Seekoe, 2014:63; Dlama et al., 2015:67; Kaphagawani, 2015:224; Ali & Ali, 2017:75; Arkan et al., 2018:131). Shoaqirat and Abu-Qamar (2013:54), exploring nursing students’ experience in Jordan, found that large numbers of students were an obstacle to achieving learning objectives. Participants in this study reported that congestion of students made it difficult for the registered nurses and mentors to teach and supervise them appropriately. These findings are consistent with those of Luhanga (2017:98), who noted

that too many students make supervision difficult and increase the risk of errors. According to Troung (2015:90), in wards with small numbers of students, preceptors had more opportunity to provide students' learning needs compared to those clinical areas that often had large numbers of students. Houghton et al. (2013:1966) in their study reported that students tend to isolate themselves if placed in one clinical setting is in large numbers, and they ultimately withdraw from potential supportive relationships in clinical settings. This study revealed that if there are large numbers of students in one ward, it does not matter whether those students are from different programmes. The students get confused and don't know what to do. According to the participants in this study, owing to the large number of students allocated to one ward, clinical staff relaxed and students had to do all the work alone, as some of the students commented: "*Oh no, the students are here! We are not going to work and that is kind_of putting you off because you are supposed to work as a team, ja, but I love nursing, I don't care if it's positive or negative, I am just there to do my thing*" (P19-y3-Fg4). This is similar with Msiska et al. (2014:38), who reported that clinical staff perceived presence of student nurses as the time for them to relax, sit back and let the student nurses to do the work.

5.2.6.6 Discrimination against students

Discrimination against nursing students in clinical settings is one of the challenges that nursing students encountered during their placements. This discrimination occurs in healthcare systems, and unfortunately nursing staff are involved in exacerbating this discrimination against nursing students (Mamaghani et al., 2018:220). This study revealed that students were being discriminated against because of the college where they were undergoing their nurse training. These findings were consistent with those of Engelbrecht et al. (2017:8494), who reported that students were discriminated against based on their place of training. Staff at the institutions preferred supervising their own students training at their hospital nursing schools. These include lower categories of nursing courses, compared with the participants enrolled for a degree course and who need more sophisticated and in-depth supervision. According to Jamshidi (2016:4) and Mamaghani et al. (2018:220), nursing students are sometimes compared unfavourably with students in other fields who are also placed in the same settings, for example, medical students, physiotherapists and occupational therapists. Participants in this study reported that they were refused the use of equipment like the Dinamap while hospital students could use the equipment. This disadvantaged students from the college tremendously, as they could not experience utilising important equipment as part of rendering quality nursing care.

Mamaghani et al. (2018:220) in their study found that student nurses had experienced discrimination in respect of distribution of resources as well, as was the case in this study. Participants of this study reported that they were treated unfairly by clinical staff, other students which were doing other nursing programmes received attention in terms of support and supervision.

Some of the nursing students shared that they felt they were not treated fairly by the ward staff. They voiced that they noticed that some students seemed to be receiving more attention in terms of teaching.

Summary

In Chapter 5 the findings were discussed and integrated with the relevant literature, which provided evidence for support or differed from the findings of this study. Chapter 6 concludes the study. Limitations and recommendations will also be discussed.

Chapter 6

Conclusions, Recommendations and Limitations

6.1 Introduction

In this chapter the conclusions of the study are discussed and the limitations and recommendations based on the study findings, are presented. The purpose of this study was to explore and describe the experiences of undergraduate student nurses from the Boland Campus during clinical practice in healthcare facilities in the Overberg region of the Western Cape. The participants were asked to describe their experiences during experiential learning in the healthcare facilities in Boland Overberg. After analysis of the data, six themes emerged which guided the conclusions of and recommendations for this study. The study was conducted in the Boland Overberg district in the Western Cape. The participants in the study were second-, third- and fourth-year students from the Boland Campus where they were studying. At the time when this study was executed, this campus was a satellite campus of a university in the Western Cape.

The objectives of the study were to explore and describe the experiences of Boland Overberg nursing students during experiential learning in the healthcare facilities in the Boland Overberg area of the Western Cape and to explore and understand student nurses' feelings during their experiential learning as well as to explore the challenges encountered by the undergraduate student nurses during this period.

Chapter 1 gave an overview of the research study. A comprehensive literature review relevant to the study followed in Chapter 2. Chapter 3 discussed the research design and methodology. Results were presented in Chapter 4. In Chapter 5, the results were discussed. In this final chapter, conclusions, limitations and recommendations are discussed. The conclusions and recommendations are discussed in relation to the three objectives in order to demonstrate that the purpose of the study was achieved.

6.2 Objectives

6.2.1 Objective One

To explore and describe the experiences of Boland Overberg nursing students during experiential learning in the healthcare facilities in Boland Overberg area of the Western Cape.

6.2.1.1 Clinical learning environment

This study explored and described the experiences of the Boland Overberg undergraduate nursing students during their placement in healthcare facilities. Participants in this study agreed that the clinical learning environment was an important factor in relation to the clinical learning of the student nurse and learning outcomes. It was evident that the clinical learning environment differed from unit to unit. Findings of this study revealed that the clinical learning in different placement settings was not the same. In some units, it was positive and conducive to learning, whereas in other areas, it was negative and discouraged learning. In a study done by Msiska et al. (2014:38) in Malawi, the students reported that due to challenges they encountered, while in the clinical settings, the learning environment does not meet its intended aim because they are not actually learning but are used as working force. The study of Baraz et al. (2015) has shown that most learning environments do not provide a positive learning situation, even though many benefits are there for students. According to the study findings, students' experiences in healthcare facilities can either positively or negatively impact on the students' learning. These students reported that they had ups and downs during their experiential learning in clinical settings, but most of them still enjoyed being in a real situation and taking care of patients. In a study done by Baraz et al. (2015), these authors found that compared with positive clinical experiences, negative clinical experiences affect attitudes and student learning in the clinical area. According to the participants in this study, taking care of patients was the only thing that gave them satisfaction and courage to continue with their nursing careers. This study showed that the atmosphere of the ward where experiential learning took place was very important. It played a substantial role in contributing to a positive or negative learning environment. According to the participants, staff attitudes contribute to a conducive or non-conducive environment for learning. The study results of Mueller et al. (2016:21) revealed that a positive relationship between nursing students and ward staff has the ability to improve the learning of nursing students. Baraz et al. (2015) concur with Mueller et al., stating that supportive relationships with nursing students enhance their learning. At the end of this study it was found that relationships between clinic staff and nursing students

were poor. King's Theory of Goal attainment (in George, 2014), states that, adequate knowledge about relationships and effective communication are necessary requirements of clinical education. Healthy relationships between clinic staff, especially professional nurses and the students, helps these professional nurses understand their students and what the students need to learn. This will lessen the students stress and frustration and will create a conducive learning environment where learning of a student nurse is enhanced. Participants confessed that they were scared to approach the clinical staff for assistance or advice. This had a negative impact on their learning, as they were discouraged from asking questions when they had problems during clinical practice in the wards. Students were ignored by the clinic staff, even when they asked for help. While students were in clinical practice, they felt frustrated and isolated as they did not understand Afrikaans, the language predominantly spoken in the healthcare facilities. This impacted negatively on the students' learning. According to the results of this study, students expected a more positive learning environment, than what they experienced. Findings from the literature suggest that experiences on the actual hospital wards differ, in a negative way, from what student nurses expect (Salamonson et al., 2015:210; Phillips et al., 2017:212).

6.2.1.2 Teaching and learning support

Klopper, cited by Van Graan and Williams (2017:280), stated that teaching–learning experience shared by role players should support and empower undergraduate student nurses as they engage with patients and should act on a vision for excellent care. This study revealed that professional nurses were reluctant to teach and support student nurses owing to the busy schedules of the wards.

According to the South African Nursing Council (2013:5), clinical settings where students are placed for their clinical practice should provide learning opportunities that meet the needs of students. Clinical support is absolutely essential. Aktas and Karabulut (2016:124-128) agree with the above statement, stating that every registered nurse has a moral duty to teach, mentor and supervise nursing students to ensure that they can deliver quality care to patients and ensure patient safety. This study reported that students were poorly supervised, as most of the time students were left alone to continue with ward routine. In the past registered nurses played a major role in providing clinical support to student nurses when the student nurses were in their clinical placements. However, currently the reality in hospital nursing is that the role of professional nurses has changed. The health services have terminated the clinical teaching department which had empowered clinical

staff duty for the accompaniment and supervision of the nursing students in the clinical setting, to ensure that they developed the competencies to become safe practitioners (Vasuthevan 2013:110; Motsilanyane,2015:30). Hence, some clinical staff in the public hospitals, refused to guide and support the student nurses during clinical practice, claiming that it was not their responsibility (Mabuda, 2008:22; Kaphagawani & Useh, 2018:106). In the South African context, there is evidence that students experience unhappiness and are dissatisfied regarding clinical support when in clinical practice (Sibiya & Sibiya, 2014:1943). All institutions where nurses are trained should be accountable for the training of student nurses and should offer evidence of clinical accompaniment or support offered to these students (SANC, 2011:8).

The college, where these students were being trained, allocated clinical educators to accompany the student nurses during clinical practice. The student nurses reported that the support they received from the clinical educators was very poor. Their visits to clinical areas were quite infrequent, owing to their workload. Participants in this study complained of the large numbers allocated in one area. According to the students, this put a burden on clinical educators. This resulted in clinical educators infrequently being in the wards and arriving only for clinical evaluations. Students, however, said that not all registered nurses were reluctant to teach them. Some were willing to take students by the hand and guide them. These students developed a love for those departments where the clinical staff were supportive and guided them. This is where learning took place effectively. This study revealed that most of the participants wanted to specialise as clinical nurse practitioners owing to the support and guidance they received while they were placed in the clinics. Students were also happy to have their peers around. The support they received from one another made their tasks easier to achieve.

6.2.1.3 Learning opportunities

This study revealed that students experienced a lack of clinical learning opportunities because of various factors. Busy wards contributed to this lack of learning opportunities. Another factor was the allocation of many students to one ward. This meant that students had to compete with one another for limited learning opportunities. This study is supported by Bray (2013:30-34) and Kaphagawani & Useh (2018:108) who found that the large number of students in one clinical setting was associated with poor learning outcomes. Students blamed the way delegation was done, as tasks were delegated to them that were either not prescribed to fulfil their objectives, or they were below the level that they were at. Clinical staff denied the students opportunities to practise what they had learned in the

nursing school. According to Kaphagawani and Useh (2013:183) and Wan & Gim (2014:10), students should be provided with opportunities to practise in real situations by doing, in order for them to learn. Time allocation for these students to spend in certain placement areas was also an issue. Participants felt that the duration in placement areas was too short. According to the participants, short lengths of stay in clinical settings limited their learning opportunities and made it difficult for students to achieve the programme outcomes. Lee et al. (2018:108) disagree with the above statement, stating that longer clinical placements do not guarantee students' positive learning experiences. According to these authors, even if clinical placements are long, if the quality of clinical education and the quality of interpersonal relationships cannot be ensured, nursing students could still have experiences where their learning is not optimised.

6.2.1.4 Inability to achieve objectives

The Nursing Act, No. 33 of 2005, states that students should acquire the learning outcomes set in a specific, identified field as part of their training, in order to be regarded competent to practise as professional nurses. This study revealed that students were unable to achieve their clinical objectives. According to the findings of this study, inappropriate delegation of students had a negative impact on the students' learning outcomes. The objectives were not considered before delegation of students took place. Students were not delegated according to their clinical learning objectives set out for their year of study. Nursing students should be placed where they are able to achieve their objectives. According to Rikhotso et al. (2014:e6), if students are not accompanied by clinical educators, chances of these students meeting their objectives are very slim. Clinical units should not forget that students are placed and rotated on a regular basis to various areas in order to achieve their objectives. It is imperative that students should not be removed from where they are allocated to work for a certain period of time and they should not be used to replace permanent staff in another department. It is important to expose these students to quality care in order to produce competent nurses that we will be proud of. To ensure that students achieve their objectives, nurse educators should be available while students are allocated in clinical settings and they should support the student nurses (Muthathi et al., 2017:e6). Kaphagawani (2015:211) highlighted the importance of allocating student nurses in clinical areas aligned to their learning objectives in order to practise what they learned in class for optimal learning.

It is clear from the aforementioned discussion, that the first objective to explore and describe the experiences of Boland Overberg nursing students during experiential learning in the healthcare facilities in the Boland Overberg area in the Western Cape, has been met.

6.2.2 Objective Two:

To explore and understand the student nurses' feelings during experiential learning at healthcare facilities in the healthcare facilities in the Boland Overberg area in the Western Cape.

6.2.2.1 Fear and anxiety

During clinical practice, students felt anxious and scared. The feelings experienced by undergraduate nurses hindered their learning in clinical placements. These students were stressed because they were facing reality: they were dealing with patients' lives and scared that they might harm the patients. According to the participants, they were left alone without supervision and that raised their stress levels. Student–staff relations play a big role in student experiences. If the students are respected and accepted, they feel more centrally located in the clinical settings and that alleviates their fear and anxiety (Melincavage, 2011:788). Peer learning assists students to develop confidence and decrease levels of anxiety (Luhanga, 2018:97). According to Melincavage (2011:788) and Liu et al. (2015:129), it is important to decrease students' anxiety in clinical settings so that these students can learn effectively, thereby securing their retention in nursing education.

6.2.2.2 Anger, frustration and embarrassment

This study revealed that during clinical placement, students suffered owing to poor student–staff relationships. According to the students, they were embarrassed by the way clinical staff treated them in front of the patients and staff. They shouted at them, belittled them, and told them that they would never survive nursing. These students experienced a great deal of frustration and anger while on clinical placement. They were left alone with ill patients, not knowing what to do. Ward staff expected them to know everything and compared them with the bridging course nursing students Regulation 683 programme (R683). Bimray (2017:215) reported that student nurses expect professional nurses to demonstrate responsibility when reprimanding or disciplining them. This should also be done in a private area, away from patients and other colleagues. Participants in this study felt that they were demotivated. This resulted in students' learning being affected negatively. Some students reported that they were emotionally abused and suffered silently

because they were alone, not knowing with whom they could share their suffering. This affected their self-esteem negatively. Feelings of frustration, lack of confidence and fear were the results of poor support from clinical educators and clinical staff (Mampunge, 2013:64). Among other issues was the language issue. Sometimes they lost learning opportunities because demonstrations were done in Afrikaans. According to Bimray (2017:207), good relationships in healthcare environments are based on a universal language that will also enhance the professional development of a student nurse.

6.2.2.3 Enjoyment moments

Wilkes et al. (2015:657), describe enjoyment of nursing work as the degree to which a nurse continues with a nursing career because nursing is intrinsically interesting. This study revealed that even though being in clinical settings was sometimes very challenging and frightening, students also had joyful moments. Seeing the patient recover gave them satisfaction and the reason to return the next day. During placements, students wanted to be accepted as members of the team. Participants verbalised that being appreciated and acknowledged made them happy and boosted their confidence. According to the students, when they were appreciated they felt valued, and that motivated them to learn effectively. Being accepted and appreciated by the clinical staff created trust between the student and the clinical staff and lessened their anxiety. It was found that a variety of daily work, support and friendship from colleagues, and opportunities for learning, enhance student nurses' enjoyment (Wilson, 2006, cited in Wilkes et al., 2015:657). According to Wilkes et al. (2015:656), the reason student nurses remain in a nursing career even though clinical staff are not supportive or encouraging, is because these student nurses enjoyed caring for patients and teaching others or their peers to care. These authors also suggested that managers and clinical educators could use their results to help student nurses to understand the importance of giving support.

The above discussion is evidence that Objective Two, to explore and understand student nurses' feelings during experiential learning at healthcare facilities in the Boland Overberg area in the Western Cape, was successfully met.

6.2.3 Objective Three:

To explore the challenges encountered by undergraduate student nurses during experiential learning in the healthcare facilities in the Boland Overberg area in the Western Cape.

6.2.3.1 Challenges

This study revealed that students were faced with various challenges which affected their clinical learning negatively. Students were exposed to more negative experiences during clinical placement. Poor communication, support and supervision hindered the learning of the student nurses. One of the main challenges encountered was the negative attitudes of the clinical staff towards them. It is important for the clinical nursing staff to know that student nurses are their responsibility too and not just the college staff's responsibility. Some of the challenges were the gap between theory and practice, anxiety, large groups of students in clinical settings, discrimination, and abuse. The students found it difficult to correlate theory with practice when they were placed in clinical settings. According to the students, there were discrepancies between what was taught in the classroom and the actual practice in the clinical settings. What was taught in the classroom was inconsistent with what was done in practice. The students reported that there were conflicting practices among the clinical staff. One professional nurse would tell the students to do a procedure in a certain way, while the next professional nurse would show the students to do the same procedure differently. This led to confusion and frustration among the students. The theory–practice gap was influenced by busy wards and the unavailability of the clinical educators. Literature has reported integration of theory with practice as a nursing education challenge (Kaphagawani & Useh 2013:184; Kaphagawani, 2015:205; Mothobi, 2017:53). Another challenge for these students was being confronted with real situations and not having effective role models and mentors. This was very stressful for students, as it affected their learning and made them doubt their competencies. It was found that students had fears of harming their patients owing to feelings of incompetence. It was clear to students that dealing with patients' lives was not like in a simulation class where they practised on manikins. Too many students in one ward was a huge challenge, as they had to compete for procedures and opportunities to achieve their prescribed objectives. This impacted the students' learning negatively. It was evident that clinical staff and clinical educators had problems in providing support and guidance to large groups of students. Students felt vulnerable and exposed when they were on clinical placements. Hence, these students were exposed to different types of violence, from verbal abuse to sexual harassment. Students were discriminated against because of the college they were attached to. This type of discrimination, together with the verbal and sexual abuse, impacted students' clinical learning in a very negative way. In some students, their self-esteem was badly affected and they felt incompetent. Literature reported verbal abuse as the most common type of violence among student nurses (Khoshknab et al., 2015:5;

Samadzadeh & Aghamohammadi, 2018:1). In a study done by Rikhotso et al. (2014:e2), students reported that some clinical staff were mean to them, using abusive language which was inappropriate and belittling, and were openly hostile.

According to the discussion, the third objective, to explore the challenges encountered by the undergraduate student nurses during experiential learning in the healthcare facilities in the Boland Overberg area in the Western Cape, was successfully met.

6.3 Recommendations

6.3.1 Recommendation for the Nursing Education Institutions

Nursing staff in the clinical placement areas in all health facilities should be encouraged to obtain a nursing education qualification. This will assist them to take their role as nurse educators, role models and mentors more seriously. They will also be better equipped to use teachable moments in their facilities, in order to strengthen their ongoing experiential supervision.

- The health services have to bring back clinical teaching departments which had dedicated professional nurses responsible for the clinical accompaniment and supervision of nursing students in clinical setting.
- All nurse lecturers responsible for theoretical lectures, should be involved in accompanying students to the practical placement areas and not evaluating students only. This is also prescribed and regulated by the SANC (SANC, 2014:3).
- All categories of staff involved with the experiential training of students need regular updates on all procedures. Clinical departments should be reinstated in all health facilities in order to facilitate updates for both staff and students. This includes lecturing staff, so that all persons involved are aware of the correct way in which nursing care should be rendered and how procedures should be managed and executed.
- Regular interpersonal skills training for staff should be arranged, in order to reduce/avoid stigma and poor attitudes and behaviour towards students in training.
- The NEIs should take responsibility to have placement rosters sent in advance to the facilities, and rosters should be done meticulously in order to allow all students to meet their objectives. Students should be placed according to their year of study

in order to achieve their objectives and to receive the necessary attention. Hence, the follow-up of lecturing staff of all students on a regular basis is important.

- Clinical staff, together with clinical educators and student nurses, should have meetings at least every three months to review the learning outcomes and whether students are able to achieve their objectives. Rosters can then be adjusted accordingly
- Large numbers of students in one unit make it difficult for the clinical staff to supervise students; therefore, when placing students, the number of students should be controlled. The nursing students should be placed where they are able to achieve their objectives, and clinical units should not forget that the students are placed in those areas to achieve their objectives. Therefore, students should not be removed from where they are allocated to replace permanent staff in another department. It is important to expose these students to quality care in order to produce competent nurses that we will be proud of.

6.3.2 Recommendations for further research

- The researcher suggests that further studies should be conducted that will explore clinical staff's experiences during supervision of nursing students.
- The role of nurse educators at NEIs to support students in breaching the theory–practice gap, should also be addressed.

6.4 Limitations of the study

- This institution where the research took place has three campuses, and this study was conducted at only one campus, hence no generalisations could be made.
- The study included only second- to fourth-year students. First years were excluded.
- Other stake holders, like registered nurses in practice, were not included

6.5 Conclusion

The aim and objectives of this study have been met. The study has revealed that all professional nurses have an obligation to assist students in the clinical environment with their experiential learning. All healthcare professionals should equip themselves to guide, mentor and educate these student nurses in training. Lecturers in NEIs have an equal responsibility to accompany students frequently in their practical placements in health facilities. They are not only responsible for teaching theoretical components but should

also play a major role in assisting these student nurses to apply theory to practice. It is only then that students will learn what it means to nurse real patients in these health facilities. The theoretical knowledge they obtain at the NEIs should assist them to gain enough practical experience and to adopt the right attitude to practice. It is nevertheless noted that proper training can play a greater role in providing them with professional knowledge and skills to practise. The study highlighted the significance of the role that all professional nurses, together with all the nurse educators involved at NEIs, play in preparing these students to become safe and competent nurse practitioners when they qualify. The importance of the entire team involved in the training of student nurses having the correct attitude, as well as knowledge of the various theoretical and practical aspects in order to care for patients daily, was highlighted. Finally, this study emphasised how important it is for all health professionals and educators to remain current with new knowledge and practical procedures in order to give advice to both students and family members on how to assist and nurse their patients skilfully and compassionately. This is significant for all the professional nurses that are part of this healthcare team, as they are the first point of contact with all the students and patients. All professional nurses and students are the caregivers that are close to the patients daily for long periods of time, particularly when students are placed to complete their experiential learning to become skilful and competent nurse practitioners. Unless all of the above is accomplished, no goal attainment will be reached.

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APPENDICES

APPENDIX A. Research Information sheet and Informed consent

Experiences of undergraduate nursing students during their experiential learning in Boland Overberg Healthcare Facilities

Principal Investigator: Fundiswa Fadana

E-mail: fadanaf@cput.ac.za

Address: 4 Stein Street

Worcester

6850

Contact Number: 083 6555369

Supervisor: Dr Hilda Vember

E-mail: vemberh@cput.ac.za

Health and Wellness Sciences Research Ethics Committee

Address:

Post-Basic Nursing Department

Faculty of Health and Wellness Sciences

Cape Peninsula University of Technology

Box 1906

Symphony Way, Bellville 7535

Contact Number: 021 9596183

Dear Participant

I am a postgraduate student at the Cape Peninsula University of Technology. I am writing to invite you to take part in a study to determine what the experiences of undergraduate nursing students are during their experiential learning at healthcare facilities. Kindly spend a few minutes to read the information given here, which will describe the details of this project. You can ask me any questions about this project that you do not fully understand. It is very important that you are fully satisfied and that you clearly understand what this research involves and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. There would not be any negative effects, if you say 'no'. You are also free to withdraw from the study at any point, even if you do initially agree to take part.

This study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki.

What this research study is about

The primary aim of this research is explore and describe the experiences of undergraduate student nurses during clinical practice at healthcare facilities.

What your responsibilities will be: As a participant you are expected to be on time for focus-group discussions.

You have been invited because you have valuable information. As second-year students you have been exposed to a hospital environment. You will be invited to take part in 50 to 60-minute group interviews.

Will you benefit from taking part in this research?

- There will be no incentives but the results of the study will be useful in the development of nursing education and the profession as a whole.
- Nursing curricula could be updated with the latest information on how to make experiential learning more beneficial to all students.

Are there any risks involved in my taking part in this research?

Your name, contact details and identity will be kept confidentially. No risk is expected but if it happens by any chance that you experience any psychological or emotional discomfort, you will be referred to the counselling unit of the university in Bellville for counselling and

support. The counselling unit is located on the ground floor of the library extension (+27 21 959 6182). I shall arrange transport, should it be needed.

Will you be paid to take part in this study and are there any costs involved?

There is no personal financial reward in participating in this study and no direct cost to you. There will be no incentives but the results of the study will be useful in the development of nursing education and the profession as a whole.

Confidentiality and Anonymity:

I assure you that I shall not divulge any information gathered except to the authorities of the college; however your identity will remain secret. The recording will be erased, and all transcripts will be locked in a safe place for five years. No-one will have access to the key, other than the researcher and supervisor.

If you need more information you can contact me at 083 6555369 or email at fadanaf@cput.ac.za or my supervisor, Dr H Vember, at 021 9596155 or email atvemberh@cput.ac.za.

DECLARATION BY PARTICIPANT:

I declare that:

I have read this information and consent form and it is written in a language in which I am fluent and comfortable with.

I have had a chance to ask questions and all my questions have been sufficiently answered.

I understand that taking part in this study is voluntary and I have not been forced to take part.

I may choose to withdraw from the study at any time and will not be penalised or prejudiced in any way.

I may be asked to leave the study before it has finished if the researcher feels it is in my best interests, or if I do not follow the study plan as agreed to.

Signed at (place) On (date) 2016

Signature of participant----- Signature of witness-----

DECLARATION BY THE INVESTIGATOR

I, declare that the information in this document has been explained to

(Name of Participant).....

I encouraged all participants to ask questions and provided adequate time to answer them.

I am satisfied that she adequately understand all aspects of the research, as discussed above.

Signed at (place) On (date) 2016

Signature of investigator----- Signature of witness----

APPENDIX B: Interview questions/guide for participants

Thank you very much for agreeing to participate in this interview. I am a master's in nursing student at the Cape Peninsula University of Technology. It is a requirement of my course to conduct a research study.

Before we start, I would like your permission to record our discussion with an audio recorder. This recording will help me to remember the things we discussed and your answers given. Whatever is said here must be kept confidential. Your name will not appear in any written report and you will not be penalised if you do not feel comfortable to answer any questions. Our discussion will take 50 to 60 minutes and you can feel free to stop the discussion at any time if you feel uncomfortable. We can start the interview if you are ready.

I consent that the interview may be audio recorded:

Signed at (place) On (date) 2016

Signature of participant-----Date:

Researcher's signature..... Date:

ENGLISH GUIDE:

1. Briefly tell us about yourself and why you chose nursing as your career.
2. How do you feel about being a student nurse generally?
3. In your own words describe your learning experiences during clinical practice at healthcare facilities.
4. What were your most positive experiences and why?
5. Tell us about challenges that you faced during this period of your study?

AFRIKAANS SCHEDULE

1. Vertel kortliks oor jouself en waarom u verpleging as beroep gekies het?
2. Hoe voel jy oor die feit dat jy 'n student in algemene verpleging is?

3. Beskryf in u eie woorde u ondervinding gedurende die kliniese praktika by die gesondheidsorg sentrums waar u geplaas is?
4. Wat was jou mees positiewe ondervinding en hoekom?
5. Beskryf die uitdagings wat jy tydens jou studie periode ondervind het?

APPENDIX C: Letter of approval from Western Cape College of Nursing



DIRECTORATE: WESTERN CAPE COLLEGE OF NURSING

Theresa.Bock@westerncape.gov.za

Enquiries: Dr T M Bock

Tel: 021 940 4567

Date: 2016/09/20

Me F Fadana

RE: Request to conduct research at WCCN:

This is to confirm that the WCCN interim Research Ethics Committee has perused your application for your research project titled "*Experiences of student nurses during practical training in health care facilities in Boland Overberg*" and the necessary permission is granted, based on the approval by the CPUH: Health Research Ethics committee.

The committee requests you to present this letter of consent to the campus and that you will make the necessary arrangements for data collection through the Head of Campus.

Please note that data collection may not interfere with the academic programme of the students and it is highly recommended that this be undertaken outside official hours

We wish you success in your studies

Sincerely

A handwritten signature in blue ink, appearing to read "TM Bock".

TM Bock

**APPENDIX D: Application for permission to conduct research at
Western Cape College of Nursing**

4 Stein Street
Worcester 6850
27/07/2016

Deputy Director: Head of Campus WCCN: Metro East

HOD Psychiatry

Acting Chair WCCN Research Ethics Committee

Dear Dr Bock

Re-application for permission to conduct research at Boland Overberg Campus

I am writing to request your permission to conduct a research project at Boland Overberg Campus which is a satellite of the Western Cape College of Nursing. I am currently enrolled as a master's student in nursing at the Cape Peninsula University of Technology.

One of requirements is a research project. This research will be under the supervision of Dr Hilda Vember, my supervisor. My research topic is: Experiences of Boland Campus undergraduate nursing students during their experiential learning in Boland Overberg healthcare facilities.

This study will only involve the second-year students registered for the R425 programme. The study will be guided by open-ended questions and students will be interviewed for about 50 – 60 minutes. The purpose of this study is to explore and describe the experiences of undergraduate student nurses during clinical practice in healthcare facilities. This study will not interfere with the academic programme and data collection will take place outside official hours.

If you need further information please do not hesitate to contact me at cell: 083 6555369, email address: fadanaf@cput.ac.za

Thank you.

Yours sincerely

Fundiswa Fadana

APPENDIX E: Support letter from student counselling



Student Counselling Department

Date: 19 September 2016

Letter of support

Dear Madam

I hereby acknowledge your request for support from Student Counselling Department, CPUT. The Student Counselling department hereby agrees to provide a counselling service to students whom may feel emotional discomfort during the process of the research project: **Title: Experiences of undergraduate nursing students during their experiential learning in Boland Overberg Health care facilities.**

For any further request contact Student Counselling at ext 6513

Kind regards

Dr Charlene Petersen
Student Counselling

**HEALTH AND WELLNESS SCIENCES RESEARCH
ETHICS COMMITTEE (HW-REC) Registration Number
NHREC: REC- 230408-014**

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28 January 2018
REC Approval
Reference No:
CPUT/HW-REC
2016/H26(renewal)

Faculty of Health and Wellness Sciences – Nursing

Dear Ms Fundiswa Pearl Fadana

Re: APPLICATION TO THE HW-REC FOR ETHICS RENEWAL

Approval was granted by the Health and Wellness Sciences-REC on 15 September 2016 to Ms Fadana for ethical clearance. This approval is for research activities related to student research in the Department of Nursing at this Institution.

TITLE: Experiences of Boland Campus undergraduate nursing students during their experiential learning in Boland Overberg health care facilities

Supervisor: Dr Vember

Comment:

Data collection permission is required and has been obtained.

Approval will not extend beyond 29 January 2020. An extension should be applied for 6 weeks before this expiry date should data collection and use/analysis of data, information and/or samples for this study continue beyond this date.

The investigator(s) should understand the ethical conditions under which they are authorized to carry out this study and they should be compliant to these conditions. It is required that the investigator(s) complete an **annual progress report** that should be submitted to the HWS-REC in December of that particular year, for the HWS-REC to be kept informed of the progress and of any problems you may have encountered.

Kind Regards



Dr. Navindhra Naidoo
Chairperson – Research Ethics Committee
Faculty of Health and Wellness Science

APPENDIX G:

Coded transcripts

FOCUS GROUP 1

0040 (1)

INTERVIEW TRANSCRIPTIONS

Name: Fundiswa Fadana

Date: 25/ November 2016

Transcription symbol

<u>Transcription symbol</u>	<u>Meaning</u>
PNo – yr-FG	P= participant No: stands for a number of participant yr.: stands for year of study and is represented by 2 - 4 depending on which year is the student An example of a code using this speaker Identifier is P2-y2-FG1 Fg stand for focus group
I.	Interviewer
All Part	All participants
(Laugh)	Laugh
Sad	sad, emotional
...:	pause

Theme colours

Enjoyment moments
Learning environment
Learning opportunities
Inability to reach objectives
Challenges.

Clinical learning and support

I: Ok. Well, information that we would like to receive from you today will be anonymous. Your identities will be completely withheld and you can speak freely. It would be great if you can speak freely and to really discuss your feelings. There will be no repercussions, no retribution of any kind for any discussions that you may have had, so please feel free to really voice your honest opinion. So, what we would like to find out is your experiences as undergraduate nursing students, how did you experience your practical clinical placements? Now, first of all, can you just give me a little bit of a brief idea as to why you chose nursing? Anybody can start.

P1-Y2-Fg1: Ok, I chose nursing because it was not my only option, but it was **the only thing I wanted to do and to give back to the community**. Since I've started nursing there is nothing else I wanted to do because I am now so into it. I love doing it, **I love working with patients**, and I love working with Sisters and the community.

I: So you really find happiness and contentment in nursing?

P1-y2-Fg1: Yes, absolutely.

I: Ok, that's great. Anybody else?

P4-y2-Fg1: I **always enjoyed working with the human body**, I have always been interested in it, especially when there is disease involved in the human body. How does it work, what does the disease do to the human body? I **also love solving problems**, like solving puzzles, so nursing to me is like solving a puzzle, **helping the patient recover when they had an illness**, explaining to them why they had the illness so that they can understand the importance of taking their medication. So in that sense I **love helping people to access knowledge about their own body**.

I: So to you it is not only a learning experience but also a rewarding experience?

P4-y2-Fg1: Yes.

I: Good. Someone else?

Only thing I wanted to do
Give back to community
I love doing it (nursing)
Love working with patients

Enjoyed working with human body.
Interested in human body disease
Love solving problems.
Helping patient recover,
Interaction with patient.

Love helping people.
Interaction with patient.

<p>P5-y2-Fg1: I chose nursing in Grade 12. I wanted to do art, but I was kind of put off by someone, so I didn't know what I wanted to do, then my mother suggested nursing because my grandma and my aunt were nurses, so I went for it. I got in but I didn't know that I will enjoy it this much. There are ups and a lot of downs but I enjoy working with people and just seeing them smile and making them happy and comfortable. It's a very rewarding profession to go into. There's a lot of downs, but a lot of ups as well.</p> <p>I: So you find it very rewarding, and it was quite a surprise to you that you enjoy it so much regardless of all the barriers and challenges you are experiencing?</p> <p>P2-y2-Fg1: I loved Biology and so I wanted to be a Biology teacher. But I don't want to bring my work home, I wanted my work to stay at work, so nursing was a good option, I could still do Biology.</p> <p>I: You could still AT: You could still do Biology, and did you find success in leaving your work at work?</p> <p>P2-y2-Fg1: Yes.</p> <p>I: Ok.</p> <p>P3-y2-Fg1: I chose nursing because I wanted to make a difference in the community and make someone happy, so I just wanted to make a difference and make people feel that they are wanted in this world and that there is somebody that care for them in this world.</p> <p>I: Ok, so you feel it was important to you to show other people that they are not alone and that there are people who take care of them?</p> <p>P3-y2-Fg1: Yes</p> <p>I: Ok, so you've had quite a number of clinical experiences in various places is that correct?</p> <p>All Part: Yes</p> <p>I: Would you like to tell me about that?</p> <p>P1-y2-Fg1 (Laughing), my experience in the hospital was bit not as I had expected. In the first year you learn bedside nursing, you do the blood pressure, temperature and so on, that is the basic that we must know. But as we got into second year we needed more learning opportunities, more challenges, and</p>	<p>Rewarding experience enjoy being a nurse enjoy working with people Making them smile and happy and comfortable. rewarding profession ups and a lot of downs Enjoy regardless of barriers and challenges.</p> <p>make a difference make people feel that they are wanted</p> <p>disappointed First year not fun</p>
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more things to get competent in. In the hospital you don't get that one on one with a Sister that she will take you and ask you to do something and you say you did the stuff. Staff will vouch for you that they saw you do the thing that you had to do, but then she (sister) would just say she didn't see you doing it and she won't sign you are competent in the book. Where as in the clinics it's different because they take you by the hand and they show you. They can take your practical book and teach the things you wanted to know so they could sign off things that are in the practical book as well. They love to teach you, they are not hesitant to take you into the clinic.

I: So it was very rewarding for you to be in the clinical environment where you felt you were not really able to achieve what you wanted to achieve in the hospital environment?

P1-y2-Fg1: Yes.

I: Some more thoughts regarding your own experiences?

P4-y2-Fg1: I have to agree with B1 in this scenario. I also felt the first year wasn't that fun for me. I felt we did know how to take blood pressure and take the glucose levels and so on, but that wasn't enough for me because there were so many things I still had to know about, not only making beds but also other things like for example needles that I had to get for the doctors and they would get irritated with me if I didn't know which needle it is. So, that was a bit discouraging for me, I didn't want to be there because I felt the Sisters are mean, the doctors are mean to me as a student. So, but second year came we did more fun things. We could do things like injections, we could do more practical things like handing out the medications, so this was a more fun year for me. And especially in the clinics. The clinic where I worked, the Sister there she was so encouraging. Ehm she will teach. She would teach us everything we wanted to know obviously under supervision. I take my hat off to her. She found ways to teach us, so that was a nice experience.

I: So you have got quite different experiences here, because what I hear you say is that a person can make a difference in your clinical experience?

Part: Yes.

Learning opportunities (involvement)

In the hospital you don't get that one on one with

clinics it's different because they take you by the hand and they show you (Difference in learning environment)

Clinical learning and support

the first year wasn't that fun (Anxiety)

discouraging for me, Attitudes of staff

Learning opportunities,

We could do things like injections, we could do more practical things like handing out the medications

They love to teach you, in the clinic

I: So the nurses you work with could make a difference to your experience?

Part: Yes.

I: Ok, anybody else?

P5-y2-Fg1: I was looking forward to work in a hospital and work with the patients and get to see how it works. I wasn't really in a hospital before I started nursing, so I didn't really know how it works. The thing that put me off the most, was that everyone was so focused on their little routine every day that there was no time for building patient relationship and getting to know the patient. We were taught this whole holistic thing, taking care of patients. This is the routine: make the beds, do observations, go feed them, start again. It kind of takes the joy out of nursing, it drains you, and the people aren't as supportive of each other. so a lot of my experiences weren't that good, but then in the clinic there's not this real routine every day, because where we worked the Sister would get quite bombarded with stuff, with different kinds of cases that she would do differently each time, so it was a lot more fun. She really knows her patients, so the clinic really was a much better experience for me. There are a couple of wards in the hospital which is awesome to work in, but not as much as in the clinic.

I: So it seems to me that the clinic seems to be the area where you felt that you were able to live what you really wanted to be?

P4-y2-Fg1: I would say in the clinic there is more opportunity for learning because in the hospital we are up to seven students in a ward from first to fourth year, so there is one or two Sisters in the ward, excluding the Operational Manager, of course, so it's difficult for her to teach a first year and a second year at the same time, because it's two different things. But in the clinic you are two students with two Sisters, and they can show you what to do.

I: So I hear you say that circumstances in the clinical environment differ, and that influences how much time you get for learning experiences?

P5-y2-Fg1:: Yes.

Looking forward to work with the patients , and get to see how it works (Anxiety)
Disappointed
little routine every day that there was no time for building patient relationship (patient care) We were taught this whole holistic thing, taking care of patients. (theory vs prac) people aren't as supportive of each other (interpersonal skill)
lot of my experiences weren't that good,

Placement unit environment
in the hospital we are up to seven students
one or two Sisters in the ward
(shortage of Srs)
Placement unit environment

Learning opportunities,

<p>I: Ok. Can you elaborate more for me when you say that things are more fun? What is fun for you?</p> <p>P5-y2-Fg1:: Ehm ,a lot of fun things happen when you talk to a patient, because you get to know the person and you start to make jokes and just be more comfortable with that patient, other than you just do your observations and no, no, it's just like, Hallo, can I do the observations? And then you do it and then you move on to the next patient, it's just the same boring thing every day, this routine thing. In the clinic there is more patient interaction and the Sister who will teach us things that the Sisters in the hospital haven't taught us yet.</p> <p>I: Good. So you find it very difficult to work in a complete routine environment where you don't get to know the patient?</p> <p>P5-y2-Fg1: Yes.</p> <p>I: Because that is what you said you first wanted to do when you started nursing – you want to get to know the people and work with them?</p> <p>P5-y2-Fg1: Yes.</p> <p>I OK, any other thoughts on that particular aspect? 12:35</p> <p>P1-y2-Fg1: I agree with P5. It's that we were taught to holistically care for a patient and to assess and to treat a patient according to the patient's needs, and that most of the time does not happen. Because it's like a very quick thing. You are on time, this time they go on lunch this time they go on tea and then you are students alone. And then they will ask you, Are you finished with this, are you finish with that, and then you don't get to know the patient better and to treat the patient according to their own illness like we were taught in our first and second year. Sometimes are glitches or we slip up and then it will be our fault because we didn't do it, and then the staff will say no you were put on observations or HGTs or Hb then they will come</p> <p>I: Ok, so you find it very task-orientated, you find there is not much support, when you need someone to assist you, there is not much support for you?</p>	<p>STUDENT EXCESS Poor supervision</p> <p>same boring thing</p> <p>Supervision learning opportunities Involvement</p> <p>THEORY GAP PRACTICE</p> <p>Not patient oriented students left alone</p> <p>Lack of support/no one to assist</p> <p>interaction with patients</p> <p>Students are blamed</p>
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<p>P1-y2-Fg1: Yes. AT: And sometimes you are being held responsible for the situations that may occur in the ward? P1-y2-Fg1:: Yes. I Can you tell me in one word how did it make you feel?</p> <p>P1-y2-Fg1: I felt anxious most of the time because it's a patient's life that you are working with and you need to treat that patient so that they can go home and treat themselves with their condition and you must help them to treat themselves. That made me anxious, because it's a life, it's not just admin work.</p> <p>I So you understand the responsibility of being in a clinical environment? P1-y2-Fg1: Yes. I: And you feel the pressure of the clinical environment? P1-y2-Fg1: Yes. I: And that is not really what you wanted to do. You wanted to be more involved with the people themselves, with your patients themselves? P1-y2-Fg1: Yes. I: OK, anyone else want to say something?</p> <p>P2-y2-Fg1:: I like my trauma unit where I worked. It's fast and there's not a lot of staff, so you get the opportunity to learn things. You get the opportunity to put up a drip, to draw blood, the staff teaches you because they are in a hurry and they want you to help them also. I liked it. I: So you like the fact that there is more stimulation? P2-y2-Fg1: Yes. I: There is not so much individual patient contact and routine, it is more task-orientated. So you like doing things? P2-y2-Fg1: I like doing things. I: And then the patient contact? P2-y2-Fg1:: There is contact with the patient, but the thing is, emergency is like you want to get the patient sorted now, then afterwards you can communicate with the patient, but the patient must be stable first.</p>	<p>Anxiety</p> <p>Involvement, like doing things placement unit opportunity to learn things (involvement) the staff teaches you Developing clinical skills</p>
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I: Ok.

P4-y2-Fg1: I also liked the Emergency room, it was such a great experience for me. I think what I liked the most is you get different cases. Every day, every hour is different, like in the clinic. Not everyone comes in with the same complaint, so I think that was the thing that made it fun. Also, you go to the doctors, they prescribe the medication, so now you get to know the medication, ok, this medication goes with that disease. Whereas if you work in a gynae ward, you only get to know gynae things. It's one thing only the whole time. I don't like just one thing, I like different things the whole time.

I: So variety is what makes it interesting for you, you like the variety?

P4-y2-Fg1: And the knowledge that you get and that you have to put out.

I: You can use the knowledge that you've learnt and deliver it in another case. You've already said that sometimes you are forced into a situation where you cannot practise what you have learnt. You learn about holistic care but it is sometimes very difficult to apply in a routine-driven situation.

Part: Yes.

I: Ok. You have said now that you have worked in a ward in clinical areas in various wards. Can you tell me which wards were those?

P1-y2-Fg1: I worked in HOSPITAL A in Ward 4A, that's a Gynaecological ward, and in Medical ward, and Orthopedic ward and then I also worked in Trauma. These were my wards in the hospital, and I mostly enjoyed the Trauma and the Orthopedic wards because it's different, even though its all bones, it's different kinds of bones and different fractures. It was nice.

I: So you also had a wide variety of clinical experience?

P1-y2-Fg1: Yes.

I: So that was mainly wards and clinics?

P1-y2-Fg1: Yes.

I: Any other areas where you have been before?

Enjoyed trauma Placement unit, a great experience for me

. I liked the most is you get different cases

Involvement

Involvement

P4-y2-Fg1: At the clinic where I worked I worked with a Primary Healthcare Sister She showed me how to put the implant in the patients and what patient care would go with that, and the suturing, most of the sutures and bandaging wounds we did at the clinic mostly, because there was not enough time at the hospital because they put the permanent staff on the wounds, not the students. So we didn't have enough time, to do the wounds, they say we are not competent, but in the hospital they need to show us so that we can get competent in the wounds, so that we can do the wounds. When we are starting next year, then they will put us on the wounds and we won't know what to do.
I: So you have worked in the wards, in the clinics, and in the theatre environment. Now tell me a bit about theatre,
All Part: (loughing)
I: It seems to be a laughing matter! , it sounds very interesting, tell me about it.

P2-y2-Fg1:: There's a different kind of vibe. And you don't care for your patient, it's just in, and out. You don't care like you learned in the first year holistically, you just oversee the patient sleeping, and when he wakes up, and the other patient comes in.

I: And the theatre environment itself? You are all cringing.

P5-y2-Fg1: I haven't had theatre yet, I'm starting on Monday for the first time. I'm looking forward to it. I don't think I'll work in theatre after I get my degree, I don't think I will work in as theatre sister, but I am really looking forward to ... I really want to catch a leg.

All Part: Catch a leg!?! (loughing)

P5-y2-Fg1:: I'm not scared of blood and sewing and so on.

I: So you are looking forward to the theatre experience? 19:00

P5-y2-Fg1: Yes, just for this one time, because I'm probably not going to do it again, because, as I said, I don't want to become a theatre sister. But I am looking forward to it.

teaching and learning

opportunity to learn
involvement

Student don't get time to
do procedures
No time to practice

I'm looking forward to it.
(Eager to learn)

but I am really looking
forward to it

I: And how do you feel about that? What do you think?

P4-y2-Fg1:: I haven't worked in theatre before either, but I won't agree with B5 on the 'catching a leg' part. but I don't like to see a doctor cutting a patient open, it's a bit gross for me, but if the patient's life depends on it, then I will be there and I think the adrenalin will just kick in. But the other wards I have worked, I have worked in Medical, in Surgical (now Orthopedics), or Gynae and Emergency Room and the clinics. My favourite is also Emergency Room and Orthopedics. There is a lot to learn in Orthopedics and the staff there is very nice. They like to teach you a lot about everything, e.g. there was a boy, I can't remember his condition's name but it was very rare, and at that time I didn't listen when they came to hand him over, and the sister came and asked me what they were saying and I told her, I'm sorry, I zoomed out for a moment. & then she told me, go and study, and come and tell me tomorrow what it is. I went home but I couldn't find it in the books because it is so rare, so I googled it. The next day I told her what I had learned, and she said, yes, that's correct, how would you treat it? So she taught me about that condition and every day we would talk about a condition she would ask me, what is this and how would we treat it? She was very nice to me. Ah ja--- medical, I don't like Medical that much. It breaks my heart to see the patients lying there so long, and you see them getting sicker by the day. Some of them do recover, I've seen miracles, it really was amazing to see the miracles in the Medical ward. Patients who couldn't stand the one day, the next day they were running up and down the ward. But I didn't like it. It's more elderly people and it breaks my heart to see them not being able to do something for themselves. So Medical is not for me.

I: Did your choice of ward have anything to do with your clinical experience in the particular ward, other than the heartache of the Medical ward?

Placement unit
the staff there is very
nice (staff attitudes)

learning opportunities

supervision and support
staff like to teach
involvement /eager to
learn

<p>P4-y2-Fg1: The staff I worked with in the Medical ward was also very nice, I liked working with them and I also had a good relationship with the Sister and the staff there. But it's just heart-breaking for me to see all the elderly people suffer so much and the families that come and visit. It's not for me.</p> <p>I: Ok. Have you had any particular experiences that you would like to share with us?</p>	<p>The staff I worked with in the Medical ward was also very</p> <p>Anxiety/ sad</p>
<p>P3-y2-Fg1: Actually I like working in the Medical ward because there I can give a lot of care to the patient. P4 said now of the family that come and visit – some people doesn't have people that come and visit, so I would go to the patient and talk to him and give that patient a sense of belonging and see that there is people he can talk to. But surgical ward, I don't like it to work there. There is no teamwork and everyone is just doing their thing. There is not a lot of patient interaction, so I don't like working in Surgical, I would rather work in the Medical ward.</p> <p>I: Tell me what contributes to your experiences in the Surgical ward? Why do you think this has happened?</p>	<p>Patient care</p> <p>no teamwork</p>
<p>P3-y2-Fg1: I don't know, but I think the people are more task-orientated than in the Medical ward. But you gain a lot of experience in the surgical ward by seeing what procedure the patient go for, but I don't like it.</p> <p>I: So you don't like the Surgical ward. Ok, is there anything else we can talk about regarding the wards you've been allocated to and that you liked? Anything more you'd like to contribute in that regard?</p>	<p>moretask-orientated</p>
<p>P5-y2-Fg1: I really want to go into Psychiatry, but of course that's only next year, but that's what I'm looking forward to, because I want to do something in Psychiatry. At the moment I don't like Surgical that much, I find it a little bit boring. Medical is sad, but I like that. I feel that I can make a change there, because if there's time, or even in my teatime or so I can go to a patient I know who can't do a lot for themselves or who can't speak or family members don't come and visit, and I can just grab a chair and pull the curtains and read to</p>	<p>]Placement unit</p> <p>Surgical that find it a little bit boring Placement unit Make a difference inpatient's life, Patient relationship</p>

them, or just sponge someone down and tell them what's going on outside. It can be very rewarding when you have time. I can go home after working in a Medical ward sometimes feeling very good.

I: Good. Am I correct when I hear you say that your experiences in terms of learning in the hospital environment is very limited because of the fact that you are so task-orientated, and what you really want to learn in the clinical environment, is difficult to learn because there's no time allocated to that?

All Part: Yes.

I: If we talk in terms of learning, we have now talked about the nurses, here and there about the doctors, what was your learning experiences like in terms of the people you worked with in the wards?

P1-y2-Fg1: The learning experience in some wards like the Gynaecological ward, the Sister asks you questions and she actually makes you feel that you can learn something today. She would also take me and, we are supposed to do the discharges, so she will take me and sit with me and show me step by step how to do it. If I don't do it correctly, she doesn't yell at me or scream at me, she would just say, This isn't correct, you do it that way and some of the other staff, they don't talk to you, they talk at you, they scream at you. We are colleagues, so you must talk assertive to one another, but they don't do that. I know it works like that in that specific ward.

I: So if I understand you correctly, what you are saying, is that it sometimes is nice to have someone who is supporting you and look out for you and almost be like your advocate in a sense?

P4-y2-Fg1: Yes.

I: And then sometimes you are in a situation where you were expected to do the work that is a large amount of work, without being supported by the hospital staff?

P4-y2-Fg1: Yes.

I: So you feel, if I'm correct in understanding you, that sometimes students are being overused?

P4-y2-Fg1: Yes. According to what P1 just said, some Sisters love teaching and you can

Rewarding (seeing patient recover)

Encouraging supervision and support

EARGER TO LEARN

she doesn't yell at me or scream at me some of the other staff, they don't talk to you, they talk at you, they scream at you(attitudes)

Some Sisters love teaching

see they love it. Others don't like students, they prefer to be on their own and do things on their own. I think that's the conflict in their clinical practices, but I must say the Sister that I've been talking about whom I worked with in the clinic, one day one of the staff members asked me to do a wound. Okay, fine, I will do it, but that's not why I was allocated to the clinic. I was allocated there for a specific task that I had to do and I had no problem with it, but the Sister went to the staff member and told her, I'm not being rude to you, but the student is not going to do your work, the student is here to learn, and I'm going to make sure she learns. That for me was great because that was the first time someone stood up for me like that and tell the other person, Listen, do your own work. She is here to study and not do your dirty work, because I could see she was stalling, she didn't want to do the work. I had no problem doing it, but I think the biggest problem at the moment is in the clinical placement the staff see us as staff. They forget sometimes that we are actually students. We are there to help them and lower the workload, yes, but they have to understand that when I have an exam and I want to study, just leave me for three hours, just so I can go and study for a while, then I'll come back and I will do my part, but I think it's very unfair if they expect us to do their work. E.g. there were countless times where I had to do observations on my own in the ward, and when I asked someone to help me, it's no, I'm busy, while they are sitting behind a desk, eating something or doing something else. So that is irritating to me and you can't say anything because then you will get in their bad books.

I: You all nod in agreement, is that your experience as well?

P4-y2-Fg1: Yes, definitely. I would also say that there are doctors from whom I learnt a lot. If they do something, I would ask them, is it okay if I just stand by and you explain to me what you are doing? You can see some of them also love teaching, they will do it with a smile, while some don't like to be around students. You can see in their attitude that they think we don't know that much. Some will just walk past you and not greet you when you greet them, but I must say I also had an

Others don't like students

staff KNOWLEDGE

someone stood up for me

Student advocacy

That for me was great because that was the first time someone stood up for me like that and tell the other person (being appreciated)

staff see us as staff
SHORTAGE OF STAFF

They forget that we are actually students

OVERWORKED

Workload, time to study there were countless times where I had to do observations on my own in the ward, and when I asked someone to help me

incident where I had to do a procedure and I went to a doctor and asked her very kindly, I am sorry to bother you, I know you're busy, but I have a procedure, will you just correct the prescription chart for me, just a few minor things. I could see she was a bit irritated, but as she went on, she didn't do the things I had asked her, so I had to ask again, and this and this please, and I knew she was irritated, but I just wanted to do good in my procedure. So then she got a bit mad and some words were said and then she left. I was upset, and when the sister in charge of the ward saw me, she asked what was wrong. I said I am going to fail because my prescription chart isn't correct, and the Sister took me by the hand literally and she went to someone and she asked them, Listen, this student needs to pass tomorrow, will you help her, please? And so I passed the next day. That was a nice Sister. Often when I had a bad experience with a doctor she just lifted my mood and just said, It's gonna be fine. And the next day before the procedure I had to find something out about the medication and there was a doctor, and I said, I know you're busy, but please, just 5 minutes of your time, and he said, Yes sure, and he didn't know the answer to the question, so he went on Google and he googled the answer for me. So you do get doctors that are irritated by you, but you get nice ones, too, who really want to help you.

I: In the experiences I've heard from you now is that sometimes the nurses and the doctors, who else in your clinical environment, affects your learning experience or has affected your learning experiences, or would you like to have involved in your learning experience, e.g. other members of the team? 35:45

P1-y2-Fg1: The physios. We sometimes lift the patients on our own and we don't have the knowledge of how to correctly lift the patient out of bed or take the patient to the toilet, and there was one physio in the Medical ward, she saw you were struggling, and she just came to us and helped us move the patient and showed us the correct way so that we don't hurt ourselves. so that was in my second year. In my first year there was

You can see in their attitude that they think we don't know that much Some will just walk past you and not greet you when you greet them (attitudes)

<p>no-one who came to us and would teach us or call a physio or occupational therapist to show us, this is how you lift a patient, this is how you help him to walk or support him. This was actually nice from the physios to come and see what we are struggling with. That was nice.</p> <p>I: So what I gathered from all you said so far is that maybe your learning experiences in the ward relate to the nurses and to the odd incident where you have the opportunity to speak to a doctor and ask a doctor, and in your first year, is that the main people that helped you, that taught you anything in the clinical environment?</p> <p>All Part: Yes.</p> <p>I: And then in your second year, were you able to approach the doctors more than you had been able to, also the physio? What about the dietician and social workers?</p> <p>P4-y2-Fg1: I haven't had that much exposure to dieticians or social workers. I only see them when I take a patient to them, so, ja, physios are mostly in the wards, so I think the dieticians have their own office, so does the social workers, so I think they would rather have the patients come to them. They can't stand in a room full of patients and talk about the services they offer, they need privacy, so I can understand why they want to be alone, but I don't know about P1, but I know the rest of us worked with the kitchen staff and I always thought it's not that bad to work in the kitchen, you make food, but the one day that I worked there, I got a lot of respect for them and I always greet them with a smile because I actually think they work harder than us. It's a lot of food to prepare and grate a lot of carrots or chop onions, so I have a lot of respect for them. They also lift the patients' mood from time to time, and the cleaners are also so helpful in the hospital situation. I couldn't translate to a patient and I asked her, could you help me, and she was a big help to me, because there was a translation barrier between me and the patient. So I think they play a very big part in the hospital, not just the doctors and the nurses. They play the biggest part in the hospital, they make the hospital.</p>	<p>Learn from other professionals</p> <p>Eager to learn</p>
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<p>I: You all nod in agreement, is that your experience as well?</p> <p>P1-y2-Fg1: I agree with P4 about the cleaners. Sometimes the nursing staff would just disappear, we don't know where they are, and then we see the cleaners, they come and feed the patients or they come and clean the patients. They talk to the patients while we are maybe busy with other patients, they talk to them while walking past them or while making the beds. That's actually quite nice. All Part: Yes.</p> <p>I: Ok. In terms of the other categories of nurses in the ward, is there anything in particular that you can say about nursing sisters, staff nurses, assistant nurses, auxiliary nurses?</p> <p>P5-y2-Fg1: There are a lot of Sisters that I have learned from or that take time to explain things to me, but a lot of the things, like medication, we learn from the Staff nurses. 40:22</p> <p>P1-y2-Fg1: Yes, because the Sisters have paperwork or are busy with this and this, but the Staff nurses are always around. I've learned more from Staff nurses than from Sisters. And then the assistant nurses also help but ... sometimes when I come into a new ward and I greet the Staff nurses and assistant nurses, they would sigh and say, oh, in a couple of years you are going to be above me, you will rule me. And I say, No, we are going to work together moss. I don't know but at some are they don't like us I don't know we didn't do anything they just want to take advantage of us. Some reason they don't like us much and they would take advantage of us.</p> <p>I: So it's difficult to want them as a teacher because they perceive you as one day you are going to not be available to them? That's what I hear you say. All Part: Yes.</p> <p>I: Ok, and anything from your side about the other categories of people?</p> <p>P2-y2-Fg1: Some people are very rank-orientated. They only help with assistant duties, they don't help with observations, they</p>	<p>Sometimes the nursing staff would just disappear</p> <p>Support from sister Sr are busy (poor support)</p> <p>Staff feel threatened by student nurses</p> <p>Attitudes from staff Some reason they don't like us much and they would take advantage of us</p>
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don't clean patients, and assistant nurses do the cleaning. They are there for all dirty jobs. Staff nurses must do the wounds and give medications, so I think a lot of people in the hospital area will only do work according to their rank, they won't do something that they don't really have to do. But you get the exceptions where some Staff nurses actually help the Sisters with a few things they don't know how to do. I've seen it quite a few times where a Sister actually learns from a Staff nurse. I also think it's about the age of the specific nurse, too. A nurse who is much older or have more knowledge will sometimes look down on a younger Sister because she knows more than the Sister does, but then you also get Staff nurses that are elderly and they act as grannies, take you by the hand and teach you everything you want to know, where a senior Sister doesn't have time.

I: So what I hear you say in terms of the professional nurse, some professional nurses make you feel that maybe you know a bit more than them because you have just studied and they have maybe not studied that much in the last couple of years, and the others are teachers, they take you by the hand and show you around? Ok. Any other thoughts in terms of the people you worked with in the wards in terms of how much they teach you, what your experiences are?

P4-y2-Fg1: I remember first year the first day that I came into the hospital I didn't know anything. Yes, I was orientated to a specific ward, but I didn't know anything, what to do, when to give this to a patient, or if I can do this for a patient. So, as you all know, we have two separate groups of students in the hospital, a group that get their qualification through the hospital and us university students. There has been this big fight apparently all these years between the hospital students and the university students, because the hospital students think we look down on them and we don't regard them as high as we see ourselves. But the first year I told them I'm not that type of person. You know more than me at this stage, please help me, and if you don't know something, I will teach you that. So they taught me how to

Some people are very rank-orientated.

A nurse who is much older or have more knowledge will sometimes look down on a younger Sister because she knows more than the Sister does

Conflict between students of different programs

correctly admit a patient, how to make a bed, I don't know how many things, but they taught me how to do it physically, also how to wash a patient, so I learnt a lot from them in my first year.

I: Anybody else who has good experiences? Have you had students from other places and from other courses with you in the clinical environment?

P5-y2-Fg1: I agree completely with P4. When we started the first year, we knew the basics and we had an idea how to do them, but the other students, the hospital students helped us a lot with that. Because they are so much in the hospital, they learn it quicker. So they were very helpful.

I: Something else you just said: They spend a lot of time in the hospital. Tell me about time in the hospital.

P5-y2-Fg1: We go to class for a couple of months and then we go to hospital for a month and then we go back to class, but they spend more time in hospital than we do, so they get a lot more practical exposure than we do.

P4-y2-Fg1: I also think it depends on what you are studying for, like I know they are studying for a diploma and we are studying for a degree. There is much more work to cover in the degree course, and I'm not saying that I'm looking down on the hospital students, but I think their workload isn't as much as ours, so I think they have more time to go and spend in the hospital. As I've heard from them, they would do a week's work and then Friday they would write about the week's work, whereas we spend three months in class and in the second or third month we would write about all the work we have done in that time. So when they do something, they finish it off, whereas we spend a lot of time on things, it is quite difficult, I think, to understand, so then we have to go and study for a week before the exam.

When we started the first year, we knew the basics and we had an idea how to do them, but the other students (Peer support)

Duration in placement area

they get a lot more practical

I: But do you think in terms of practical and learning in the clinical environment itself, do they get more time in the clinical environment than what you do? Is that what you are saying?

P4-y2-Fg1: Yes, they do get a lot more exposure than what we do, but it's because they have time to do it. We don't necessarily have the time, and because we need to be placed in clinics in the area as well. They don't have to be placed in clinics, so I think ours is more specific, e.g. where we need to work, like Surgical 300 hours have to be completed. They just have to finish 1 000 hours, doesn't matter in which ward, as long as it's covered.

I: So you see it as that you are far more rigid in terms of where you are placed, where you have to work, the amount of hours you have to complete? That's quite restrictive.

P4-y2-Fg1: Yes.

P1-y2-Fg1: I agree with St-4 completely.

I: Ok. Can you tell us something that is particularly positive for you or that is particularly negative according to your experience? If you think in terms of this last two years that you have been studying and working in the hospital, what has been an outstanding positive experience that you had with regards to the clinical accompaniment? It's interesting to me that we've spoken about the staff in the wards. Who other than the staff is also involved in your education in terms of accompaniment?

P4-y2-Fg1: I would say our clinical nursing Sisters, lecturers, the mentors, because they are the ones teaching us how to do certain things in that particular year, e.g. in our first year they taught us how to do observations, every type of observation. In the second year they taught us how to give injections, put up a drip or something like that. So they obviously play a big role, because they are the ones teaching us and when we have procedures they will be the ones standing there with the marks. They play quite a big role.

P1-y2-Fg1: In one hospital we only had three clinical educators, so it's a bit rushed with us.

exposure than we do

Mentors play a big role in student learning

I: So is it your experience that sometimes you don't really get the opportunity to have enough exposure to practical procedures prior to having a formal assessment?

P4-y2-Fg1: Yes.

I: And that you feel that that was not a positive experience?

P4-y2-Fg1: No, it was not.

I: In your opinion, what was outstanding for you? What was really, really good and what was less good for you in terms of learning and your clinical experiences in the ward?

P3-y2-Fg1: The positive for me was we are working in a team in the ward, and when somebody is sitting, we are all sitting. It's not that you are sitting and everybody else is working. It was teamwork and I like it because you have to be a team in the ward because we need to take care of our patient's needs, so you work that side and I work this side and so we take care of the patient. You are there for the patient's needs. For me it will be bad if there's no teamwork, because the patient is not going to receive the care they need to get, and we are there to take care of them. Some Sisters are nice to work with and they teach and help you by correcting your mistakes and so on. Some help you but they don't really want to help you, so they leave you at your own mercy there and then you just have to make a plan if something went wrong. Sometimes some of the Sisters are rude, but not as much anymore, and it's actually the assistant nurses that are above us who want to tell us what to do. The Staff nurses teach us about wounds and medication, some of them teach us a lot. The Staff nurses just do wounds the whole day, so they will say, Come with me, let's do this wound, but it's just wounds the whole day, there's not variety.

They don't do anything else. You need to be a team in the hospital. 57:10

I: But teamwork to you is more important, but some of your experiences are the same as the other students here, but yet you say to me that where other students may have found the Staff nurses very supportive, sometime you don't, and the auxiliary nurses and Staff

The positive for me was we are working in a team in the ward, and when somebody is sitting, we are all sitting. (ward atmosphere) (teamwork)

Some Sisters are nice to work with and they teach and help you by correcting your mistakes Some help you but they don't really want to help you, Sometimes some of the Sisters are rude

Support from nursing staff

nurses can sometimes not be all that kind. Is that sort of a general feeling?

All Part: Yes.

I: Ok. Anything more that you can add to the conversation that we've had now so far with regards to your clinical experiences that you had? Is there something that you think could, if we know about it, could be addressed in some way?

P2-y2-Fg1: This year we struggled a bit, the second years, with CNP and I don't think it's the Fees Must Fall situation. It's the fact that we needed to practise and be able to go to the hospital and go and ask the lecturers if they are available and stuff, but also learning opportunities in class because in class we get more theory than physical help. We do not actually feel in touch and get that feeling of doing the things.

I: You said class. Which class are you referring to? Is it your lecturing class or which class?

P2-y2-Fg1: In lecture class but also in Simprac class. We are in groups because we are too much to do the same procedure.

I: So there are many students in a group? That then affects your learning opportunity?

P2-y2-Fg1: I think that's the reason why most of us failed this year. Last year it wasn't a problem because we had time to practise and the lecturers went out of their way to help us.

P4: I would also say in some classes we could practise on something like dolls. Don't get me wrong, the dolls are very helpful, but they are not a person. They don't have feelings, you can't feel the flesh. You get different sizes of people also. Let's look at having to give the injection. You get thinner people where you get the muscle easier, but with people who are bigger it's difficult to actually find that spot where to place the needle, and the dolls are really thin. So I think that has also been a barrier to us, especially with a catheter. There was a male doll but if you do it in real life, it's not the same than with a doll. The doll has an opening and you see it clear but with a patient you don't always see the opening and get the touch what it feels like.

Reality vs simulation

Large number of students

time to practise

Reality vs simulation

I: So you find that in certain places simulation is not a good tool to use for teaching clinical procedures?

P4-y2-Fg1: No.

I: Ok. If you could give us some indication of what do you think needs a change? What should be done to improve your situation, to change your situation? Just give me your thoughts, please.

P1-y2-Fg1: may be more clinical educators and a bit more practice in hospitals so that we can ok... My experience with the medication and injection, the Sister, when I worked in Orthopedics, you get a lot of morphine injections, and I told the Sister that I need to practise because I have a procedure the next week, and she gave me all the morphine injections in the ward. I had to give deltoid or in the group we did everything. That was nice. Also that the Sisters and the staff in the wards will be more approachable to the students because that's also a thing that I think we are struggling with.

I: You say approachable. Do you find that there's, in terms of the word approachable, is it a feeling that you have that you can't speak to other people? 1:

P1-y2-Fg1: It is that when you ask a Sister, please show me this or I need to do this, can she help me? Then some of them, not all of them, will say, No, I don't have time, go ask somebody else, and that's the thing. If somebody says that to me I will never ask that person again to help me I'd just struggle on my own and get it right or I'd ask the clinical educators or someone else, a third year or fourth year, please help me. That's what I would do.

I: What do you think in terms of nursing *per se*? Do nursing students learn a lot, are they treated well?

P1-y2-Fg1: In some cases we are treated well, but overall we are used, we are overused. We are sometimes burnt out and then sometimes where I worked, you are off that night, but the Night Matron asks if you want to come and work. And if you say no,

may be more clinical educators and a bit more practice in hospitals so that we can ok
(Recommendation)

No support

Sim lab vs reality
In some cases we are treated well

<p>then you have an attitude, and if you say yes, you may be working five or six nights in a row just to stay in her good books. Otherwise they will never ask you again or say, This student is not helpful. That's why we are burnt out.</p> <p>I: So on occasions you are asked to come and do additional shifts?</p> <p>P1-y2-Fg1: Yes.</p> <p>I: By the permanent staff in the hospital?</p> <p>P1-y2-Fg1: Yes.</p> <p>P4-y2-Fg1: I think this relates to what I said earlier, that we are seen as hospital staff and not as students. Some instances e.g. where it's near the holiday seasons I would ask if I can work three 7 shifts back to back so that I can go home earlier and be with my family because I live on a farm and I want to get there earlier. And then they would actually tell me sometimes, No, meaning that I am part of their staff. I don't think we are supposed to be seen as part of the staff, firstly because we are not employed by the hospital, they don't pay us. We are students. I applied to a university and because I have to finish my practical hours, I have to do it here, but I don't think it's fair for them to see us as hospital staff.</p> <p>I: Any other thoughts where that's concerned? Any other really positive things you'd like to say or to make some recommendations on how you would like to see things done differently so that you can learn more?</p> <p>P2y2-Fg1: I think they should not put so many students in one ward because as I said, there were about sixteen students plus it was first years, second years and the hospital students and the permanent staff is also there. We don't know what to do, we don't know the other staff, and we can't go to another ward because we must work there. So I don't think they must put so many of us together.</p> <p>I: What do you think is the greatest problem with having too many students in the ward at one time?</p> <p>P2-y2-Fg1: They don't work. They sit and if you ask them to help, they will say, No, there are students.</p>	<p>overall we are used, we are overused sometimes burnt out</p> <p>think this relates to what I said earlier, that we are seen as hospital staff and not as students</p> <p>because then we are understaffed</p> <p>there were about sixteen students plus it was first years, second years and the hospital students and the permanent staff is also there,.</p>
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<p>I: So then some people ...</p> <p>P2-y2-Fg1: Yes, only some people are working. The permanent staff don't really want to work because there are students, they can work.</p> <p>I: And learning opportunities in that particular situation? 1:00</p> <p>P2-y2-Fg1: Like I had this situation where we were four second years on a shift that day and I think it was an oral medication procedure and we all had to practise. It was a bit confusing and who must go when and who must do in the morning and who must do in the afternoon. Then sometimes we go out of the ward and back in the ward and we didn't know where we must be.</p> <p>I: So it's confusing when everybody is there together. Is there anything that you would like to mention that could improve your learning opportunities or conditions conducive for learning?</p> <p>P3-y2-Fg1: For me the stuff that we learned in class must go with experience in the ward. We are supposed to do obs in the first year and medication in the second year but we are still doing obs this year and we don't get exposure to the things that we actually must learn in the year group that we are in. In hospital we don't get much exposure to do the things that are in the book which we must learn how to do.</p> <p>I: So you are expected to provide holistic patient care but what you would like to do is to focus more on your learning outcomes at that particular time?</p> <p>P3-y2-Fg1: Yes.</p> <p>P2-y2-Fg1: I would like to learn what I am supposed to be learning but I would also like to do the holistic patient care.</p> <p>I: Do you want more time to be able to do what you have to do to be able to reach your objectives?</p> <p>P2-y2-Fg1: Yes.</p> <p>I: Ok. Anything from your side?</p> <p>P4-y2-Fg1: I think that staff should just be made aware of it. I know the hospitals are helping a lot and are doing us a big favour in letting us do our practicals there but I think</p>	<p>They sit and if you ask them to help, they will say, No, there are students.</p> <p>The permanent staff don't really want to work because there are students</p> <p>Then sometimes we go out of the ward and back in the ward and we didn't know where we must be. STUDENT EXCESS</p> <p>No exposure / unable to meet learning outcomes</p> <p>For me the stuff that we learned in class must go with experience in the ward (theory vs practise)</p> <p>(theory vs practise)</p>
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just sometimes they need to be reminded that we are students, don't punish them that much. Allow them space and teach them the things they need to know this year, because if they don't know this by now, they will never know it. There are times when you are in practical that you just don't see something, e.g. I have never seen a PEAK FLOW but it had to be signed off in first year. It was demonstrated to me, but personally seeing it and getting a demonstration are two different things. So I just think they need to be reminded from time to time just how the students need to learn.

I: They must become more student-friendly

P4-y2-Fg1: Yes. They are very friendly towards the doctor students but not to the nursing students. When I see the nurses see the doctor students, they get this glow over their faces and they say, what I can do to help, and the doctor students would say, ag, do that or do that, and they would do it.

I: That's an interesting point.

P1y2-Fg1: My one good experience was also in Peds with doctor students and the Head of Department of Peds. He just came in one day and asked, Where are the students? Then he said he wants all the students and he took us with on doctor's rounds. We didn't feel excluded, he also asked us questions and when the doctors didn't know, we answered and when we didn't know, he would give us that answer, and that made us feel a part of the hospital, a part of the learning opportunities of the team, and that was fun. But to the rest of the ward we are ...

P1-y2-Fg1: Yes, because that was the first time that somebody, a doctor, said, Come with us, we are not just there ...

I: It made you feel valuable.

P1-y2-Fg1: Yes.

I: Anybody else had a similar experience?

P3-y2-Fg1: Sometimes you also get a good experience in theatre where they tell you what to do and the doctors would also help you.

P4-y2-Fg1: I also think radiologists, they are very fun to work with. When I take the patient out for X-rays, even if it's just for 10 minutes, they will explain to me why the patient must

think that staff should just be made aware of it
Allow them space and teach them the things they need to know this year

Attitudes of staff

No learning opportunities

Involvement /eager to learn

It was a bit confusing and who must go when

Sometimes you also get a good experience in theatre where they tell you what to do and the

be in this position, they are always very interacting with us. When I ask them why they are pushing this button and not that one, they would always take time to explain to me, even if there's a long line.

I: So it's nice to be made to feel equal?

P4-y2-Fg1: Yes, and I also thinks it improves our knowledge, e.g. when the physios sometimes send a patient back to us, the patient is not clean. But I think when you actually work with the physios in that situation where the patient is supposed to be not clean, you can understand the need to do certain exercises, like with hand exercises. If the patient's hands are dirty, they feel uncomfortable, so now they need to put on gloves or whatever, but then they can't help the patient as much. Or with the X-rays, when we send the patient, make sure the patient is comfortable, and there has been times where I had to go with the patient to help the radiologist move the patient or put the patient on her side. So I think sometimes we just need a bit of exposure of other practices so we can enhance our knowledge of how and why they need us to do certain things.

I: So we are able to learn from each other?

All Part: Yes

I: And that makes you feel as if you are an equal member of the team?

P4-y2-Fg1: A simple example: sometimes the doctors get frustrated because they think the kidneys aren't working while they are actually working well at the time, and they need to increase or reduce the doses, and sometimes we just need to be made aware of why they ask certain questions.

I: Ok. Anything else that you would like to add?

P5-y2-Fg1: I can't at this moment think of anything else. One thing: In the ward you get all the different ranks: the Sister, Staff nurse, auxiliary, students, doctors, but what some of them don't realise is that, even if you are a Sister, doesn't matter how many stripes you have, you are there to do everything, not just one thing, do paperwork or just do wounds. And in a ward you don't really get Sisters who help you make up a bed or wash patients. It's more the students and assistant nurses who

doctors would also help you. (support from other members of multidisciplinary team)

Eager to learn

do that, and they can do other things, but if you work together, you can get things finished faster and you will have more time to spend time with a patient. I think that will help for more one-on-one with a patient.

I: Ok. That certainly would be nice, hey?

All Part: Yes.

I: Anything else? I have exhausted all your experience and knowledge and I would like to thank you very much for sharing this time with us. Your input was extremely valuable. Thank you very much. 1:18

End of 0040 (1) – 1 hour 8 minutes

APPENDIX: H

ES VAN ASWEGEN

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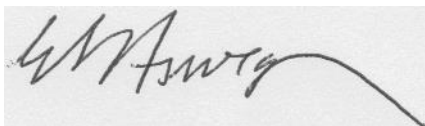
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The Master's in Nursing thesis by Fundiswa Pearl Fadama titled 'Experiences of undergraduate nursing students during their experiential learning in Boland Overberg healthcare facilities' has been edited, the references have been checked for correctness and formatting according to CPUT Harvard bibliographic citation guidelines, and the candidate has been advised to make the recommended changes.

A handwritten signature in black ink on a light grey background. The signature is cursive and appears to read 'ES van Aswegen'.

Prof ES van Aswegen

17 March 2019