

**UNIVERSITY OF KWAZULU-NATAL**

**EXPLORING STUDENTS PERCEPTIONS REGARDING THEIR  
ROLES AND RESPONSIBILITIES IN THE CLINICAL SETTING  
AT A SELECTED NURSING EDUCATION INSTITUTE (NEI) IN  
KWAZULU-NATAL**

**Juliette Maritz**

**2017**

**Exploring Students Perceptions Regarding their Roles and Responsibilities in  
the Clinical Setting at a Selected Nursing Education Institute (NEI) in  
Kwazulu-Natal**

A dissertation submitted to the University of KwaZulu-Natal, School of Nursing  
and Public Health, in partial fulfilment for the award of a Master's degree in  
nursing (Nursing Education)

By

Juliette Maritz

Student number: 215079589

Supervisor: Ms M. Dube

March 2017

**DECLARATION**

I, Juliette Maritz, declare that the dissertation on EXPLORING STUDENTS' PERCEPTIONS REGARDING THEIR ROLES AND RESPONSIBILITIES IN THE CLINICAL SETTING AT A SELECTED NURSING EDUCATION INSTITUTE (NEI) IN KWAZULU-NATAL hereby submitted by me as partial fulfilment for the Master's degree in nursing (Nursing Education) at the University of KwaZulu-Natal is my own independent work and has not been previously submitted by me at another university/faculty.

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1<sup>st</sup> March 2017 \_\_\_\_\_

**STUDENT SIGNATURE**

**DATE**

(Mrs. Juliette Maritz)

Student number: 215079589

\_\_\_\_\_

1<sup>st</sup> March 2017 \_\_\_\_\_

**SUPERVISOR'S SIGNATURE**

**DATE**

(Ms. M. Dube)

## **DEDICATION**

The dissertation is dedicated to my husband, for his unending support and encouragement, to my parents who instilled in me the value that knowledge is power and lifelong learning and the support they gave me. To my brothers and sisters that are supportive and believe in me.

## **ACKNOWLEDGMENT**

I wish to express my gratitude to the following people and organisations for their contributions toward the completion of this study:

To the Lord my God for blessing me with an opportunity to study, and for carrying me through my studies;

The respondents of this study whose contribution made the study possible;

Principal Mofokeng for allowing access to her private school of nursing;

My supervisor for encouragement; and

Grace Dongoo for guidance and input into my study.

## ABSTRACT

**INTRODUCTION:** Discontent can exist between students and qualified staff, due to the nature of the work student nurses requested to do. The Minnesota Nurses Association (2011) in United States reports that nursing students and registered nurses frequently ask questions to determine what the differences are between the students' roles as a student versus an employee, including questioning what the rights are of the registered nurse when delegating work to student nurses. Role clarity is a crucial issue for effective inter-professional collaboration. Poorly defined roles can be a source of conflict in clinical teams and reduce the effectiveness of care (Brault, 2014).

**AIM:** The study aimed at exploring the students' perception regarding their roles and responsibilities in the clinical setting at one of the Higher Nursing Education Institutions in KwaZulu-Natal.

**METHODOLOGY:** A quantitative, non-experimental, explorative design in this study was used. The researcher administered a questionnaire to undergraduate students' on the four primary domains of nursing students' perceptions regarding their roles and responsibilities in the clinical setting. Selected by convenience, non-probability sample technique. Data collected included the socio-demographic characteristics of the participants. SPSS Ver. 24 was utilised to analyse data within the four domains. The Chi-squared test performed, test for association between the background characteristics of the undergraduate students and the perception of their roles and responsibilities in the clinical setting.

**RESULTS:** The findings indicate that participants of this study had a moderate mean score of 83.3 and standard deviation  $\pm 8.00$  for their roles and responsibilities. The majority of respondents 84% had a median score of 83 and  $\pm 8.00$  standard deviation (moderate score) and more. Only a minority of 15.5% had a low score of 75 and below with standard deviation of  $\pm 8.00$ .

**CONCLUSION:** A quarter of the participants' have a perception of being merely observers, while just over a quarter of respondents were not used as extra pair of hands. More so, the respondents' ability to prioritise their learning were less than half. The support in the clinical setting perceived by participants was low with the result being just more than a quarter of the participants.

## **LIST OF ABBREVIATIONS**

ANA:	American Nurses Association
CIHC:	The Canadian Inter-Professional Health Collaborative
ICN:	International Council for Nurses
IPC:	Inter-professional Collaboration
IP:	Inter-Professional
SANC:	South African Nursing Council
SAQA:	South African Qualifications Authority

# TABLE OF CONTENTS

DECLARATION .....	ii
DEDICATION .....	iii
ACKNOWLEDGMENT.....	iv
ABSTRACT .....	v
TABLE OF CONTENTS.....	vii
INTRODUCTION .....	1
1.1 Introduction and Background.....	1
1.2 Problem Statement .....	5
1.3 Purpose of the Study .....	6
1.4 Research Objectives .....	6
1.5 Research Questions .....	6
1.6 Significance of the Study .....	6
1.7 Operational Definition of Terms.....	7
1.7.1 Clinical Setting.....	7
1.7.3 Perceptions .....	7
1.7.4 Responsibility.....	7
1.7.7 Student Nurse.....	8
1.8 Conceptual Framework.....	8
Figure 1: Competency Framework: Role Clarification.....	8
1.10 Conclusion .....	11
LITERATURE REVIEW .....	12
2.1 Introduction.....	12
2.2 Roles and Responsibilities .....	13

2.2.1 Role Clarification.....	13
2.2.2 Student Responsibility Regarding Communication and Skills Development in .....	14
2.3 Challenges Perceived by Students in the Clinical Setting .....	15
2.3.1 Student Ethical and Professional Conduct: Honesty, Respect, Protection and Provision of Care.....	15
2.3.2 Theory Practice Gap.....	16
2.3.3 South African Nursing Council (SANC) Requirements for Clinical Learning Experiences .....	17
2.4 Support of Students in the Clinical Setting .....	19
2.4.1 Supernumerary Status .....	19
2.4.2 Accessing Others Skills and Knowledge Appropriately .....	25
2.4.3 Enhancing Leadership Skills.....	35
2.4.4 Student Attributes .....	35
2.4.5 Staff Beliefs.....	36
2.5 Conclusion .....	37
<b>RESEARCH METHODOLOGY .....</b>	<b>38</b>
3.1 Introduction.....	38
3.2 Research Paradigm.....	38
3.3 Research Approach .....	38
3.4 Research Design.....	39
3.5 Research Setting.....	39
3.6 Study Population .....	39
3.7 Sampling and Sample Size.....	40
3.8 Inclusions and exclusions.....	41
3.9 Research Instrument.....	41

3.10 Validity and Reliability of the Instrument .....	42
3.10.1 Validity.....	42
3.10.2 Reliability.....	43
3.11 Data Collection Process .....	43
3.12 Data Analysis .....	44
3.13 Ethical Considerations .....	44
3.14 Data storage.....	46
3.15 Data dissemination .....	46
3.16 Conclusion .....	46
ANALYSIS AND PRESENTATION OF RESULTS .....	47
4.1 Introduction.....	47
4.2 Sample Realisation and Response Rate .....	47
4.3 Socio-Demographic Data.....	47
4.4 Description of Respondents' Perceptions of Their Roles and Responsibilities in the Clinical Setting.....	48
4.4.1.1 Participants Overall Score on their Perceptions Regarding Roles and Responsibilities about Nursing Care .....	52
4.4.2 Roles and Responsibilities in the Clinical Setting: Learning.....	52
4.4.2.1 Participants Overall Score Perception About their Roles and Responsibilities about Learning .....	54
4.4.3 Respondents Perceptions Regarding Their Challenges in the Clinical Setting.....	56
4.4.3.1 Participants Overall Score on Their Perceptions Regarding Challenges in the Clinical Setting .....	58
4.4.4 Respondents Perception Regarding Support of Students in the Clinical Setting from Facilitators, Mentors, Supervisors, Preceptors and Educators.....	59

Setting .....	60
4.4.5 Overall Perceptions of the Respondents Regarding their Challenges in the Clinical Setting .....	61
4.4.6 Association between Respondents’ Socio Demographic Variables and their Overall Perceptions regarding student Roles and Responsibilities in the Clinical setting .....	62
4.5 Summary of Findings .....	63
4.5.1 Roles and Responsibilities Regarding Nursing Care .....	64
4.5.2 Roles and Responsibilities Regarding Learning .....	64
4.5.4 Roles and Responsibilities Regarding Support .....	64
4.6 Conclusion .....	65
DISCUSSION, CONCLUSION AND RECOMMENDATIONS .....	66
5.1 Introduction .....	66
5.2 Discussion .....	66
5.2.1 Participants Socio-Demographic Characteristics and their Perceived Roles and Responsibilities .....	67
5.2.2 Participants’ Overall Perceptions Regarding their Roles and Responsibilities in the Clinical Setting.....	69
5.2.3 Participants’ Scores in the Four Domains.....	69
5.3 Association between Students’ Socio-Demographic Variables and Perceptions Regarding Their Role and Responsibilities .....	72
5.4 Conclusion of Results .....	73
5.5 Limitations of the Study.....	74
5.6 Recommendations .....	74
REFERENCES.....	77
LIST OF ANNEXURES .....	82

## LIST OF FIGURES

Figure 1.1: Competency Framework: Role Clarification.....	8
Figure 4.1: Histogram reflecting sum of roles and responsibilities: Nursing Care.....	52
Figure 4. 2: Histogram Illustrating The Sum Of Roles And Responsibilities In The Clinical Setting: Learning .....	55
Figure 4.3: Histogram Reflecting Sum of Challenges Perceived by the Respondents in the Clinical Setting .....	58
Figure 4.4 Histogram Reflecting the Sum of Support Perceived by Respondents in the Clinical Setting .....	61
Figure 4.5: Histogram Reflecting Respondents Overall Score Regarding their Perceived Challenges in the Clinical Setting.....	61

## LIST OF TABLES

Table 3.1: Content Validity of Instrument .....	42
Table 4.1: Socio-Demographic characteristics of respondents	48
Table 4.2: Roles and responsibilities in the clinical setting: Nursing Care .....	49
Table 4.3: Roles and responsibilities in the clinical setting: Learning .....	53
Table 4.4: Information on Perceptions of Students' Regarding Their Challenges in the Clinical Setting .....	56
Table 4.5: Level of Agreement and Disagreement Regarding Support of Students in the Clinical Setting from Facilitators, Mentors, Supervisors, Preceptors and Educators.....	59
Table 4.6: Chi-squared test between respondents' background variables and their perceptions Regarding their Roles and Responsibilities in the Clinical Setting .....	62
Table 4.7: Participants mean scores on their overall roles and responsibilities and their four sub-domains .....	63

## **LIST OF ANNEXURES**

Annexure 1: Research instrument .....	82
Annexure 2: Information leaflet.....	86
Annexure 3: Informed consent form.....	88
Annexure 4: Application for permission to conduct research.....	88
Annexure 5: Letter granting permission to conduct the study .....	90
Annexure 6:Ethical clearance .....	91
Annexure 7:Editor’s certificate .....	92

# CHAPTER 1

## INTRODUCTION

### 1.1 Introduction and Background

A common view shared globally that, for students to gain valuable and positive experiences in the clinical setting, students must be active participants in the setting provided. Clinical placement is encouraged both nationally and internationally to ensure that students develop the skills required for competent practice. Through clinical experience, students learn to integrate theory with practice and acquire professional attitudes and values. Research conducted by the University of Worcester (2012) in the United Kingdom, suggests that the roles and responsibilities of student nurses in the clinical setting, should be as knowledgeable observers and participants. In addition, student nurses need to have enthusiasm and passion. The Virginia board of Nursing (2012) Of United States set out the responsibilities of the student nurse, to guide practice and to enable students to have meaningful clinical experiences.

Discontent can exist between students and the qualified staff, due to the nature of the work student nurses are asked to do. The Minnesota Nurses Association (2011) in United States reports that nursing students and registered nurses frequently ask questions to determine what the differences are between the students' roles as a student versus an employee, including questioning what the rights are of the registered nurse when delegating work to student nurses. The Nursing and Midwifery Council (2011) of the United Kingdom drew up a few key principles that should underpin the practice of all nurses and midwives to remind them of their roles and responsibilities. The standards of conduct support professional development and thus student nurses and professional nurses should always refer to the code of conduct, ethics and performance to reflect on their responsibilities, learning and development (Goldberg, 2011). Respect, honesty, protection and providing a high standard of care, are just a few, of the nursing responsibilities that they need to strive for. These responsibilities are in line with the International Council for Nurses' (2010) (ICN) of United Kingdom view that the fundamental responsibilities of nurses in all spheres are to promote health, prevent illness, restore health and alleviate suffering. Furthermore, ICN (2010) states that elements of nursing, which are nurses and people, nurses and practice, nurses and profession and nurses and co-workers, must be

internalised and understood as a living document to achieve the purpose of the code. This will give a framework to students for the standards of conduct in their study and work lives.

Student nurses have the role of bringing fresh eyes, unhindered by rituals and past practice, and a vested interest in the future of the profession (Quallington, 2012). An opportunity exists for student nurses to participate in shaping the future of nursing. It is not only the responsibility of all nurses to provide the best attainable care for all patients but also to reflect on practice and to enhance care. When nurses understand their responsibility, the provision of inappropriate care is preventable. Awareness will empower them to take action. The view is in line with the Virginia Board of Nursing (2012), the University of California Policy Statement (2014) and the University of Tasmania in that student nurses should demonstrate self-direction and they should be actively involved in learning experiences. Student nurses must maintain confidentiality, professionalism and accountability in performing assigned care. The American Nurses Association (ANA) Code of Ethics (2005) sets the standard for the responsibility of professional nurses by ensuring that only those individuals who have demonstrated knowledge, skill in practice, commitment and integrity, enter and continue in the profession. No task is knowingly delegated to a member of the nursing team, that the person is not prepared or qualified for performing such a task (ANA, 2005). However, student nurses have a responsibility to be “signed off” on completed practice requirements in a timely manner and to attend shifts according to the roster, unless sick.

Student nurses should demonstrate self-direction through seeking learning experiences actively and ongoing basis. Student nurses should prepare for each clinical experience and should provide nursing care at the highest level of the students’ knowledge and ability. Student nurses not exposed to the clinical experience first, quickly conform to fitting-in and coping with the reality of becoming a professional nurse. Donaldson (2003) reports that students become like visitors in the ward with insufficient hands-on experience. They still need to learn the in hospital culture and ward routine that, in essence, creates the smooth path toward the final goal, thus learning survival skills (Gray, 1999).

The result is that student nurses that are unable to integrate theory and practice, end up negotiating to leave a specific area of learning to join another area to gain experience. The University of South Hampton Health Sciences (2010) reports that student nurses are not merely observers of practice but students gain experiences determined by their learning needs, therefore program providers must ensure that student nurses are supernumerary during all practice

learning. The researcher of this study is also of the view that another solution to overcome the theory-practice gap is adequate clinical supervision in the clinical environment by the professional nurse serving the role of guidance counsellor and preceptor and an informal role as clinical teacher, as stipulated in Regulation 425 of South African Nursing Council (2014). The informal role involves delegating tasks. The traditional role of student nurses being dependent shifted to a role of independence and student-centred. As a result, nurse educators that support and empower student nurses to solve problems. Students are the able to evaluate situations in their learning environments.

In a study conducted in Gauteng on students' experiences of clinical settings, every individual has a specific role and function in such a setting, of which one is to perform tasks effectively (Mntambo, 2009). Researchers (Mntambo, 2009; Coetzee, 2014; Allan, 2009; Houghton, 2014) agree that a facilitator's role is to enable the student nurse to develop skills and knowledge appropriate for their functions. It is concluded that this enabling role is developmental as it seeks to make student nurses effective in the tasks they perform to release their inherent potential. However, student nurses' experienced difficulty in meeting the goals set by their academic institutions because of the inadequate clinical experiences students received.

Mabuda (2008) concur that in the clinical setting, student nurses not only experience the human side of nursing but they acquire the knowledge, skills and values that are pivotal for their roles and responsibilities in the profession. "Students become socialised into the nursing profession" (Mabuda, 2008: 19). The researcher of the study concludes, from literature, that the student nurses' responsibility is to learn how to become professionally mature practitioners who are competent. However, students are dissatisfied and express concern about their clinical placements. This is possibly due to the shortage of staff in South-African clinical setting, which sees a disregard for the student role as learner and the lack of recognition of the student nurses' learning needs. Mabuda (2008:22) makes the point that "ward staff were not teaching students, apparently because they did not have the education qualifications, were not paid to teach student nurses and did not have time due to heavy workloads". Thus, there was a reluctance to act as role models and mentors, which is fundamental in clinical learning because "nursing is a practice discipline with a high level of responsibility and accountability" (Mabuda, 2008:23). Respondents of the study reported that when they were students, their role was just to observe and to record vital signs. Thus, the clinical setting was not conducive for student nurses to embark on their roles and responsibilities shaping the future of the nursing profession that would

include teaching, learning, supervision as preceptors and assessors of future novice nursing students. Mabuda (2008) reports that if preceptors were absent in wards, students would rely on ward sisters who were too busy to supervise and guide.

Nurse educators and professional nurses all have a common function in the clinical setting, namely to support the students (Vallant & Nevelle, 2006, cited in Coetzee, 2014). A more supportive and encouraging attitude is developed by professional nurses once they understand that it is essential to develop and promote student learning (Andrews et al., 2006, Lillibridge, 2007 cited in Coetzee, 2014). Due to professional nurses being liable for student nurse support in the clinical setting, the support rendered can be particularly challenging if the professional nurse is experiencing an excessive workload (Ehrenberg & Haggblom, 2007 cited in Coetzee 2014).

An advantage related to collegial support and teamwork in the clinical setting is that it enables student nurses to spend more time with professional nurses because of a reduction in work and therefore they can engage in valuable learning experiences (Carlson et al., 2010). Fitzgerald & McAllen (2007) are of the view that support of student nurses in the learning environment is a substantial investment not only for student nurses but also for the future of nursing and must therefore be valued.

Research conducted by Cunze (2016) (Life Healthcare), reports that role models are valuable resources in the clinical setting. However, professional nurses will only provide partial opportunities for student nurses to imitate their behaviour as role models. Cunze (2016) is of the view that skilful role models enable students not only to discover knowledge in clinical practice but also to internalise the role models' behaviour and build on previous knowledge and experience. Although risk-taking, independent learning and experimentation is promoted in the South African clinical environment, care should be taken as students should be held liable for their actions and mistakes, therefore, students are not only responsible for their actions in the safe care rendered but also for the tasks initiated by themselves (Coetzee, 2014). Purposeful guidance and support of pre-graduate students and their learning needs, according to South African Nursing Council, Regulation 41 (1985) will result in the development of safe and professional practitioners. In addition, student professionalism and personal growth enhances when meaningful learning opportunities and experiences correlate. In view of this, the South African Nursing Council supports the right of student nurses to negotiate continuing professional education, as may be directly or indirectly related to his/her responsibilities.

Thus, students do routine and menial tasks, and no delegation of students takes place to perform tasks that are in line with the students' level of training or scope of practice. Another compounding factor that negatively impact the roles of the students is the discrepancy that exists between theory and practice. Students observe the difference between their training and by the the actual patient care. Respondents stated, "at times you find that what you are taught in class is not exactly what you find in practice" (Mabuda, 2008:23). In addition, Buthelezi (2014) report that for male students the clinical environment is overwhelmingly negative due to the unpreparedness of males in the profession that is female dominated. The students' responsibility to complete mandatory skills and competencies to become competent practitioners were unfulfilled. Male respondents reported they had no allowance in time, nor opportunity to learn.

## **1.2 Problem Statement**

Role clarity is a crucial issue for effective inter-professional collaboration. Poorly defined roles can be a source of conflict in clinical teams and reduce the effectiveness of care (Brault, 2014). Feelings are documented well among students of their unpreparedness, powerlessness and dissatisfaction in clinical experiences, these feelings are recognised globally (Shepherd, Uren, 2014; Jeggels, Traut, Africa, 2014, Mabuda, 2008; Buthelezi, 2014). As a result, student roles and responsibilities are affected in addition attributed to the student learning experiences not allocated in relation to their learning needs, and students become aware of the fact that in the placement setting they are extra 'pair of hands' (Shepherd & Uren, 2014). Many nurse researchers repeatedly report on negative experiences of student nurses in the clinical setting. Mabuda (2008) states that studies conducted by Lipinge and Venter (2003) found that expectations of student nurses were not met as staff were unaware of student objectives. There were, frustrations due to poor integration of theory and practice and lack of support and guidance of student nurses.

In addition, during placement in the clinical setting there is an expectation for students to learn and become professionally mature and competent practitioners in nursing. Thus, clinical learning is an integral part of nursing education (Mabuda, 2008).

It is reported that globally student nurses and registered nurses frequently need to ask themselves what the difference is between students' role as students and what their roles and responsibilities are in the clinical setting (NMC, 2011). The reported dissatisfaction experienced in the clinical setting prompted the researcher to investigate formally what perceptions the

students have of their role in the clinical setting, challenges and support as perceived by students in the clinical setting. The researcher will explore the students' perceptions of their role in the clinical setting at one of the Higher Education Institutions in KwaZulu-Natal

### **1.3 Purpose of the Study**

The study aimed at exploring the students' perception regarding their roles and responsibilities in the clinical setting at one of the Higher Nursing Education Institutions in KwaZulu-Natal.

### **1.4 Research Objectives**

1. To explore students' perceptions regarding their roles and responsibilities for care in the clinical setting;
2. To explore students' perceptions regarding their roles and responsibilities for learning in the clinical setting
3. To explore students' perceptions toward their perceived challenges in the clinical setting;
4. To explore students' perceptions regarding perceived support in the clinical setting.

### **1.5 Research Questions**

1. What were the students' perceptions of their role and responsibilities for care in the clinical setting?
2. What is the students' perceptions regarding their roles and responsibilities for learning in the clinical setting?
3. What were the challenges as perceived by the students in their clinical setting?
4. What were the students' perceptions of support in the clinical setting?

### **1.6 Significance of the Study**

There was limited research conducted into perceptions students have about their roles and responsibilities in clinical settings in Higher Nursing Education institutions in South Africa.

- Nursing Education: Findings from the study may assist in increased output of competent nursing professionals when studies are completed as the study may identify the possible shortcomings in role and responsibility clarification;
- Policy Makers: Higher Education Institutions may find the feedback from students valuable and this can lead to changes in clinical experiences for nursing students with regard to their roles and responsibilities; and
- Nursing Practice: Findings from this study may clarify students' perceptions of their roles and responsibilities in the clinical setting.

## **1.7 Operational Definition of Terms**

### **1.7.1 Clinical Setting**

Collins dictionary (2016) defines clinical setting as a place of observation and treatment of patients directly. Buthelezi (2014) defined clinical setting as the environment in which a registered nurse and a student are involved in patient care and where learning opportunities present themselves. For the purpose of this study, the clinical setting was a public hospital institution.

### **1.7.2 Nursing Education Institution**

*South African Nursing Council (2005)* in terms of the Nursing Act, 2005, (Act No 33, of 2005), institution means a founded establishment or organisation consisting of a building or complex of buildings and its associated resources for the specific purpose of offering nursing education and training programmes.

### **1.7.3 Perceptions**

The Oxford dictionary (2000) defines perceptions as the ability to notice things quickly. Merriam Webster (2015) defines perception as the way you think about or understand someone or something. In this study, perception described the way that a person notices or understands something using one of their senses.

### **1.7.4 Responsibility**

The *Oxford Dictionary* (2000) defines responsibility as the state or fact of being accountable or to blame for something. Department of Higher Education Massachusetts (2007 – 2017) define responsibility as the state or fact of being accountable or to blame for something. Recognizing that she/he is accountable for the quality of care she/he provides within the established objectives.

### **1.7.5 Role**

*Oxford Dictionary* (2000) define role as to play a part. Department of Higher Education: Massachusetts (2007-2017) define role to play a part in the care of patients by applying their skills and knowledge under the guidance of and instructor.

### **1.7.6 Role clarification**

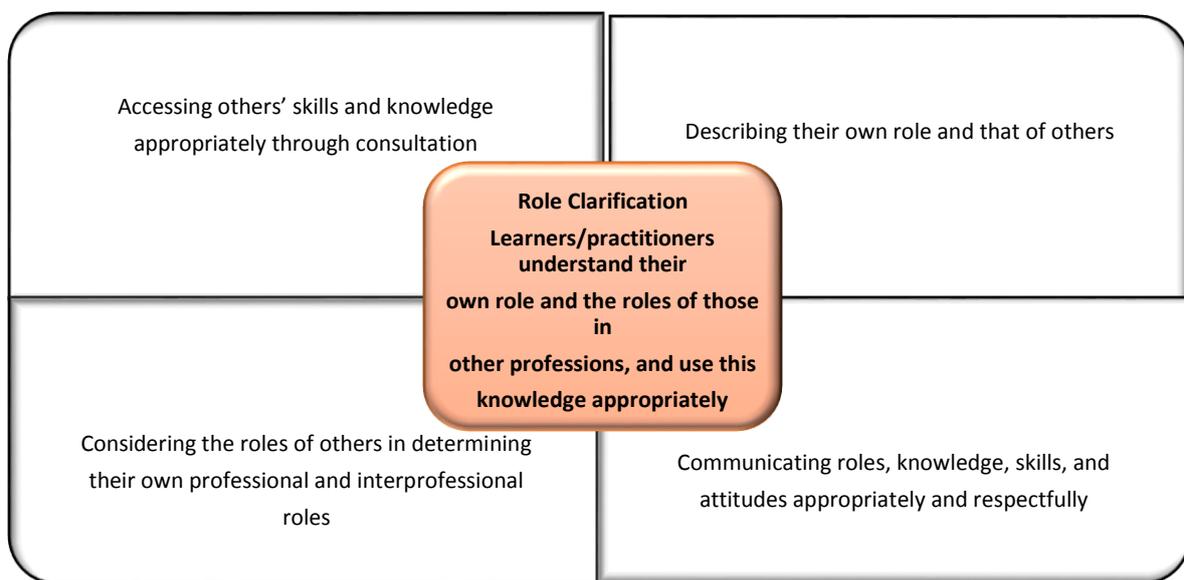
*Mosby's Medical Dictionary, 9<sup>th</sup> Edition (2009)* define role clarification as gaining knowledge, information, and cues needed to perform a role.

### 1.7.7 Student Nurse

According to South African Nursing Council Regulation R425 (22 February 1985) revised (2010), a nursing student is any individual who is registered for a four-year nursing course leading to registration as a nurse (general, psychiatric, community or midwifery).

## 1.8 Conceptual Framework

Framework developed by the Canadian Inter-Professional Health Collaborative: Competency framework: Role clarification (CIHC, 2010:11).



**Figure 1.1: Competency Framework: Role Clarification**

The Canadian National Inter-professional Competency Framework was developed by the Canadian Inter-professional Health Collaborative (CIHC) in 2010. Consisting of academics, researchers, health professionals, students, and health organizations that are concerned with training for inter-professional collaboration and the associated competencies (Canadian Inter-professional Health Collaborative, 2010). This framework defines the competencies required for better collaboration; it positions role clarification as one of the fundamental competencies for optimizing inter-professional collaboration. This framework is relevant for two reasons. The framework presents shared vision of the competencies associated with inter-professional collaboration and it allows us to link specific activities with the implementation of the role clarification competency. A better understanding of the processes involved is gained.

The Canadian Inter-Professional Health Collaborative set out an overall goal of interprofessional education and collaborative practice to enable health systems users to achieve improved healthcare outcomes. It is reported by the Canadian Health Collaborative that interprofessional collaboration (IPC) occurs when learners/practitioners/patients/families and communities develop and maintain working relationships that facilitate optimal health outcomes. Thus, inter-professional education (IP) was established. The Inter-Professional Competency framework provides an integrative approach to describe competencies required by student nurses. Six competency domains highlight knowledge, skill, attitudes and values that shape judgements essential for inter-professional collaborative practice.

The six identified domains are inter-professional communication that examines the responsible and effective communication within the inter-professional team. Role clarification and team functioning where the mechanism and principles that must be understood in effective team functioning. Collaborative leadership where shared decision-making is of importance and inter-professional conflict resolution, all members are required to engage in conflict resolution. The ability of learners and practitioners to collaborate is developmental. The effect is that each competency develops over the professional lifespan of the individual and implemented within relevant practice. Four domains integrated in whole are: role clarification, team functioning, inter-professional conflict resolution and collaborative leadership. The Canadian Health Collaborative (2010) is of the view that role clarification competency is fundamental to interprofessional collaboration and is defined by seven descriptors. The role clarification descriptors include the following: Describing one's own role and that of others, recognising and respecting diversity of other healthcare and social care roles. In addition, the responsibilities and competencies, performing own roles in a culturally respectful way; communicating roles, knowledge, skills, and attitudes using appropriate language; accessing others' skills and knowledge appropriately through consultation; considering the roles of others in determining own professional and inter-professional roles; and integrating competencies/roles seamlessly into models of service delivery.

Role clarification occurs when student nurses/practitioners understand their own role and the roles of others and use this knowledge appropriately to establish and achieve patient/client and community goals. Quallington (2012) states that not only do students develop skills but also they provide the best care attainable under the circumstances. Student nurses will also be able to reflect on practice to enhance care. Student nurses need clarity to articulate their roles,

knowledge and skill within the clinical setting. In order to support inter-professional collaborative practice, student/practitioners need to demonstrate role clarification through describing their own role and that of others recognising and respecting diversity of other health and social care roles. Competencies carried out should be culturally respectful, using appropriate language.

Student nurses need to be able to articulate clearly, their roles, knowledge and skill within their clinical work especially when there is discontent between students and qualified staff related in relation to tasks. The student nurse must communicate by being friendly, courteous, polite, and must use clear, accurate and effective communication skills in professional interactions.

All parties need to be able to listen to the other professional and to identify where knowledge and skill occur. To gain the most out of clinical experiences and to function to the full scope of practice, students must frequently determine who has the knowledge and skill needed to address the needs of clients to allow for appropriate use of practitioners more suitable for the support required. Thus, a familiarity with the curriculum supports the educators and professional nurses to educate, assess and support student learning outcomes in order to bridge the theory - practice gap (Coetzee, 2014). The South African Nursing Council stresses the importance of meaningful learning opportunities and experiences for students.

‘Student professional socialisation’, according to Houghton (2014), is a vitally important component in student nurse education and should be considered by student nurses when determining their own professional and inter-professional roles as it leads to thinking that is most appropriate for the nursing profession.

Accessing others’ skills and knowledge appropriately through knowledge gained from the clinical experience and practice placement, leads to students developing the prescribed level of confidence. Henderson (2012) is of view that interactions vary among staff and students. Smith (2011) argue that, a designated mentor need to be assigned to student nurses when entering practice placement.

## **1.9 Research methodology**

This study followed the positivist paradigm that is closely associated with the quantitative research approach. A quantitative, non-experimental, explorative design was selected. In chapter 3 discussion of research methodology is further elaborated upon.

## **1.10 Conclusion**

This is the introductory chapter to the research study. It gives background information, problem statement, objectives and research questions, significance of the study, operational definitions and conceptual framework that will guide this study. The following chapter deals with literature review, that is organized in themes and sub-themes that emerged from the reviewed literature.

## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 Introduction

Literature review definition is a process of searching, finding, reading, understanding and forming conclusions about published research and theory on a particular subject (Brink, 2003). The computer-based literature search was done on EBSCOhost database. The databases that were used for literature search included Google Scholar, Medline, ERIC and through Science Direct, other articles were accessed.

The key search words/phrases included the following: roles of student nurses, responsibilities of student nurses, clinical setting roles and responsibilities, student status.

A literary review in quantitative research influences the development of several steps in the research process. The purpose of the literature is similar for the different types of quantitative research. The review started at the beginning of the research process and continues throughout the development of the research proposal, collection and analysis of data, and interpretation of findings (Burns and Grove, 2009). According to Mongwe (2007), a literature review is a systematic search of published works to gain information about a research topic. The rationale for review of literature in this study is to gain background understanding of the information that will be relevant to the study. The reader can regard this as an extension to the background in chapter one.

Students need to feel part of a ward nursing team and part of a wider profession. Allan (2009) states that students need to be included in the nursing work which they are qualified for and students need to observe and participate in bedside care and technical work to learn how to supervise care. Data suggests that qualified nurses focus on tasks that only they can do, while students deliver unqualified care (Allan, 2009). Concern exists on how students learn as supernumeraries and how this affects the way students think about nursing.

## **2.2 Roles and Responsibilities**

### **2.2.1 Role Clarification**

The researcher will now focus on the roles and responsibilities of the nursing student in the clinical setting as it encompasses a large component of practical experience in a wide variety of settings.

Quallington (2012) from the University of Worcester in the United Kingdom suggests that the roles of the student in the clinical setting will include being a knowledgeable observer and participant. In addition, the student should have passion and enthusiasm. Henderson (2011) concurs with this view and state that students are encouraged to observe actively and to participate through asking questions about practice.

The student nurse furthermore has a role to play in bringing fresh vision to the task unhindered by rituals and past practice. Student nurses have an interest in the future of the profession and they have the opportunity to participate in shaping the future. Quallington (2012) states that it is the responsibility of all nurses to provide the best attainable care for all patients and to reflect ethically on practice to enhance care. Nurses have a responsibility to be aware of others providing inappropriate care and to act on this when this occurs in practice. The view is in line with Virginia Board of Nursing (2012) in United States, the University of California in their policy statement (2014) and with the University of Tasmania in Australia, in that students will demonstrate self-direction and be actively involved in learning experiences. The Nursing and Midwifery Council (2011) of United Kingdom set key principles to underpin practice for all nurses and midwives. This is a reminder of their roles and responsibilities in the clinical setting. The standards of conduct, performance and ethics support professional development and therefore nurses and students should refer to the code to reflect on their responsibilities, learning and development (Nursing and Midwifery Council, 2011). The responsibilities are in line with the International Council of Nurses (2010) that the fundamental responsibility of nurses in all spheres is to promote health, prevent illness and alleviate suffering. South African Nursing Council scope of practice, acts and omissions section 4, Chapter 4 of Nursing Act 1978 (Act 50 of 1978) support the view by stating that action shall be taken against a registered nurse where wilful or negligent omission to maintain the health status of a patient under their care, is not maintained. ICN code of ethics (2010) state that the elements of nursing are: nurses and people, nurses and practice, nurses and profession and nurses and co-workers. This must be internalised

and understood as a living document to achieve the code's purpose, which is to give a framework to standards of conduct in study and work lives of students.

Students should maintain confidentiality, professionalism and accountability in performing assigned care. Student nurses' responsibility as mentioned in chapter one, is "to be signed off" on completed practice requirements in a timely manner, and to attend roster-scheduled shifts unless sick. Critical reflective thinking and maintaining motivation is of the utmost importance to develop as a professional. Nursing students should not undertake any care outside the scope of practice and should always ensure that direct supervision from a Registered Nurse is available. The Department of Massachusetts (2015) supports the view that student nurses, in general, should understand the objectives and learning outcomes of their course. Students should also contribute to development of their clinical experience and look for opportunities to learn from the clinical area. Students' have another responsibility to recognise and notify their educator if learning objectives is not achieved. The Department of Massachusetts Higher Education (2015) contended that it is a responsibility of the student to complete assignments before leaving the clinical setting.

Preparing for each day maintains professionalism. Dressing and acting professionally. Professional boundaries should be established and maintained. Student nurses have a responsibility to provide care to assigned patient, without discrimination, and should treat each patient with courtesy, respect, dignity and individuality.

### **2.2.2 Student Responsibility Regarding Communication and Skills Development in the Clinical Setting**

The student nurse has a responsibility to use clear, accurate and effective communication skills in professional interactions. The student should obtain reports from staff or preceptor prior to giving care and they should collaborate with staff members. Furthermore, the student needs to communicate conflict between individual cultural values, ethics or religious beliefs and some aspects of clinical experience.

In summary Franklin (2013) suggests that the student nurse's role in the clinical setting is to learn under supervision. Furthermore, the student has the role of helping staff as part of the team, more so to learn about the team and its dynamics. The student should not practice outside their scope of knowledge and skill as student. The student must remember that they are not there to staff the ward or to fulfil the role of another nurse. Sivitier (2013) maintains that the student

nurse is not in the ward to deliver one-on-one patient care. The students need supervision themselves.

Students' are afforded rights and responsibilities of both a legal and ethical nature. Clinical faculty needs to be aware of these in order to protect the students' rights while holding them accountable for their responsibilities (Fressola & Patterson, 2016) Students should carry cognisance of their responsibilities into the clinical setting.

### **2.3 Challenges Perceived by Students in the Clinical Setting**

The review of literature under this theme examined evidence covering three critical areas of students' clinical learning experiences. These included: issues relating to student ethical and professional conduct, challenges in bridging the theory-practice gap and the South African Nursing Council requirements for clinical learning.

#### **2.3.1 Student Ethical and Professional Conduct: Honesty, Respect, Protection and Provision of Care**

Providing inappropriate care and acting against this when it occurs in the practice can be prevented if nurses understand their responsibility of being aware. The view is in line with the Virginia Board of Nursing (2012), University of California Policy Statement (2104) and University of Tasmania in that students will demonstrate self-direction and be actively involved in learning experiences. The responsibilities students have is to maintain patient confidentiality, professionalism and accountability in performing the assigned care. The American Nurses Association Code of ethics sets direction to those individuals who have demonstrated knowledge, skill in practice, commitment, integrity not to knowingly delegate tasks to a member of the nursing team that is not prepared or qualified to undertake such a task (ANA, 2005).

**Honesty:** honesty is more than just telling the truth; it is the substance of human relationships. There are many ways to portray honesty, such as by following through on commitments made. Being honest with oneself is also part of honesty. As a student, if you are unsure of the task allocated to you, do not proceed with the task because of pressure to complete the task. Dishonesty in academic and clinical settings can involve cheating on skills exams or submission of other students work as their own, interventions not performed or medicines not given. Dishonesty in direct patient care is in violation of the code of conduct and exposes the student to liability in the form of a charge of professional negligence (Emmerson, 2007). Honesty is linked to providing and protecting a high quality of service in the clinical setting.

Professional ethical codes serve as useful, systematic, normative guidelines for providing direction and shaping behaviour. ANA and ICN codes of ethics apply to all nurses regardless of their roles (Butts, 2013).

Even with the code as a guide, it is believed that nurses without virtuous character cannot be dependable to act in a good moral way.

**Respect:** Butt's (2013) report claims that ANA (2001) characterised various ways as to how nurses demonstrate their primary responsibility to their patients. The responsibility included having compassion for patients, showing respect to patients and to each other. Author Butt (2013) reports that nurses treat other nurses in hurtful ways through horizontal and lateral violence. Horizontal violence involves interpersonal conflict, harassment, intimidation, criticism and sabotage. This is often a result of feelings of oppression by other dominant groups in healthcare. Horizontal violence is counterproductive in the nursing profession. Nurses should strengthen and support other nurses' successes rather than treating them poorly. Nurses should end their day by examining their actions in dialogue to others, which is a means of selfreflection.

### **2.3.2 Theory Practice Gap**

In first placements reality hits home when students realise their clinical placement area does not reflect what they have learned. The Virginia Board of Nursing (2012) defined roles and responsibilities of student nurses to guide practice and for students to have meaningful experiences in the clinical setting. These include a student nurse to demonstrate self-direction through actively seeking learning experiences. Student nurses should prepare for each clinical experience and must provide a high level of nursing care. However, previous research reports that students conform to fit-in and cope with the reality of becoming a nurse and therefore students become like visitors in the ward. The result is that students are unable to integrate theory and practice and or to negotiate to leave a specific area of learning to join another to gain experience (Mabuda, 2008).

Although the theory-practice gap is widely discussed, the theory-practice gap refers to nursing as a discipline that is subject to change and development on a continuous basis (Coetzee, 2014). In order to develop new theories, techniques require verification. Once new theoretical concepts and techniques rejected by nurse practitioners, the result is a theory-practice gap which is not only a local problem, it is also an international one. To overcome the gap, the implementation of clinical supervision is the solution. Allen (2008) states that the theory practice gap can exist

when students are taught theory in their learning setting and then the experience in the clinical setting does not correlate with this. When a new theory application is required, students find themselves in a predicament of how to apply the theory in a clinical setting.

In order to bring together theory and practice, supervision is a requirement. The professional nurses are entrusting to bridge the theory-practice gap. It cannot not be taken for granted that students will on their own accord incorporate theoretical knowledge into the clinical setting (Coetzee, 2014).

Researchers, Hanberg (2006) and Coetzee (2014) reported that the theory-practice gap had several repercussions for students. For example, there is decreased optimal patient care and time wasted during inclusion or exclusion of newly verified knowledge. Hanberg (2006) argued that bridging the gap might enhance the students' knowledge and therefore, patient care that rendered improve as a result.

A familiarity with the curriculum enables nurse educators and professional nurses to educate, assess and support the student learning outcomes. The theoretical knowledge of the students is used in order to bridge the theory-practice gap (Coetzee, 2014). The University of South Hampton Health Sciences (2010) suggests that students should not be merely observers of practice but students gain experiences determined by their learning needs, thus, program providers should ensure that students are supernumerary during all practice learning.

South African Nursing Council (2005) stresses the importance of creating meaningful learning opportunities and experiences for students to correlate theory and practice. Due to emphasis placed on the meaningful integration of theory into practice, the South African Nursing Council Regulation R425 have minimum requirements that can lead to registration (based on Regulation R753) (SANC Regulations: Education and Training of a Nurse and Midwife, 1987). A result of the regulations minimum requirements for pre-registration, students' professional and personal growth is enhanced and independent, safe and professional nursing practitioners are developed.

### **2.3.3 South African Nursing Council (SANC) Requirements for Clinical Learning Experiences**

The SANC (1985) stipulates the subject curriculum for the four-year comprehensive program (R425) to enable students to gain clinical experiences including the expected clinical hours exposure in a clinical setting. The clinical hours' exposure is in line with the *Basic Conditions of Employment Act (Act 75 of 1999) of South Africa* (Basic Conditions of Employment Act,

1997). A forty-hour work week is specified and student nurses are not excluded from these conditions when in the clinical setting. The SANC R425 further stipulates that Nursing Education Institutions that provide the four-year comprehensive program should also provide pre-graduate students with classroom (theoretical) and clinical (practical) learning opportunities. The nurse educator should facilitate the clinical component better known as Clinical Learning Experience. With the successful completion of the four-year program, pre-graduate students qualify as professional nurses (General, Psychiatry and Community) and Midwife (R425, 1985). As the student regulatory body, the Nursing Education Institution is registered with SANC for student nurse training (SANC Regulations: Education and Training of a Nurse Midwife, 1987).

The clinical placement of pre-graduate students ranges over the four years of training. Rotation of the students takes place during this time in placements ranging from medical and surgical wards to theatres, casualty, community and psychiatric units and maternity units. These settings provide the general nursing, psychiatric and midwifery science components for registration.

These requirements are consistent with the Department of Health's policy (2007) on Quality of Care in South Africa. More so, with the changes throughout the world in nursing education to meet the demands of world health demands that are ever-changing, a national commitment to continuously improve, measure and maintain high quality of care for all citizens is required (Department of Health Policy, 2007). Research conducted suggests improving the educational quality of learning environment through direct and indirect facilitation of the individuals' development. Armstrong (2008) states that higher education institutions are required by *The Higher Education Act, 101 of 1997* and *SAQA Act, 58 of 1995* to comply with specified quality standards. Furthermore, the pre-graduate students are viewed as the primary customer of the Nursing Education Institution, and in order to improve the quality of nursing education student customers should have input via the conducting of surveys. The feedback of the surveys serves to redesign and refine educational practices to change the way of current practice.

According to the South African Nursing Council, Regulation 42 (1985) (SANC Regulations; Education and Training of a Nurse Midwife, 1985), accompaniment involves conscious and purposeful guidance and support of the pre-graduate student and their learning needs. In terms of the *Nursing Act, 33 (2005)*, nurse educators are required to accompany pre-graduate nurses in the CLE to give guidance and support and to integrate theory into practice.

## **2.4 Support of Students in the Clinical Setting**

The examination of evidence for students' support during clinical learning encompasses supernumerary status, accessing others' skills and knowledge appropriately, students' attributes and staff beliefs.

### **2.4.1 Supernumerary Status**

In effect students become critical thinkers and self-directed. The supernumerary status's aim is for students to become "increasingly self-directed as the educational programme progresses and to explore areas of skill and knowledge on an individual basis" (Elcock, 2006:2). In effect students become critical thinkers and self-directed learners.

Ultimately, supernumerary status of students should mean that the service delivery would continue without the student's presence and that students would be able to negotiate to leave a specific area of learning to join another area to gain experience. In order for students' supernumerary status to be upheld, "Programme providers must ensure that students are supernumerary during all practice learning" (University of South Hampton Health Sciences, 2010:1). This does not mean that students are merely observers of the practice but the experiences the students gain determine their learning needs. It is important to remember that students are supernumerary throughout their course, but in order to develop the required skills, "students need to participate in different clinical activities under direct or indirect supervision" (AFB Amendments, 2012:2).

Smith (2012) reports that confusion exists between universities with regard to students' supernumerary status. This tension exists due to the need to learn and on the other hand, the need to work. Belief exist that every university clearly defines, in their documentation, guidelines to supernumerary status. Smith (2012) reports that one university stated that it did not include the student counted for in the number of nurses required to deliver care.

Furthermore, Smith (2012) contended that the students' educational needs is dominant and this takes preference over service needs. In addition, reminding students' that they are not merely onlookers, and that the experience of giving care as a part of professional team member and helpful participant is vital to learning.

Previous studies, as reported by Smith (2012), revealed tension and ambiguities in both interviews and questionnaires. The concept of supernumerary status was troubling and difficult to balance. Firm statements made by universities about the student, who is a learner on the one

hand, and on the other is part of a team involved in delivering care. Both aspects were vitally important to learning.

#### **2.4.1.1 History of Approaches that Lead to Supernumerary Status**

The process of development of supernumerary status period represent the culture shift in nursing education. In light of the student roles and responsibilities that have over time changed to improve education, the supernumerary status history form part of the clarification of the student roles and responsibilities.

In 1956 an experimental study program in Scotland, students were placed in wards in addition to the staff complement. The Nightingale system of training, dating from 1860, based on an apprenticeship model, has formed a prototype for nurse education and training for over a century. A study done in Ireland revealed pitfalls with the apprenticeship model with a weakness revealed in the lack in clinical teaching and too much focus on working in the setting (Mabuda, 2008). A study done by Elcock (2006) argued that the apprenticeship model still exists thus, affecting the students' ability to integrate theory with practice. Transformation in the nursing education was required and recommendations made by the Nursing Board of Ireland were for students to cease employment status as students and to transfer to student supernumerary status. Several authors in example O'Callagan and Earmonn (2003) have questioned the suitability of this model for nursing education.

According to these authors, prior to the implementation of student supernumerary status via Project 2000, nurses were largely reliant on the medical model, with its positivist influences, to guide education and training.

Project 2000 adopted the supernumerary status of students and unfortunately, guidelines lacked about the meaning of supernumerary status in Ireland. The aim of project 2000 was to have "knowledgeable doers" (O'Callagan & Slevin, 2003:123). Project 2000 opened the gates to attract more nurses as there was a crisis in nursing recruitment. Project 2000 highlights practice teaching for the students that led to the introduction of assessors' courses for sisters. With the implementation of the Common Foundation Programme, "the programme was found to be too adult-based" (Donaldson, 2003:11).

One of the outcomes of the Common Foundation Program was that the learners felt that there was still a lack in their practical skills. Later studies done in Scotland was of the view that the

Common Foundation Program was “inadequate in relation to theoretical input, practice development and branch-specific preparation” Clarke (2008).

The inception of Project 2000 led to students no longer being a pair of hands but challenges existed due to the definition and a clear understanding of the role of students, lecturers and staff. Donaldson (2003) reported that there was initially apprehension from practitioners toward implementation of the supernumerary status. Practitioners did not completely embrace the new approach when shortages in staff existed. As a result, students became resentful due to insufficient support from practitioners. In keeping with studies previously done, Donaldson (2003) reports that findings of the studies were that students became like visitors in the ward, with not enough hands-on experience and that the focus was more on academics. It was believed that students would have a “reality shock” when qualified.

Smith (2012) argued that with the increase in the practice curriculum that was required by project 2000, the previous difference in ratio of theory to practice were modified from (60 theory – 40 practice), to a 50-50 ratio. Smith (2012) reported that universities used student portfolios to link theory and practice learning. Not only did the portfolios record significant learning experiences but also provided a basis for student and mentor discussions.

The Researcher concluded that the strengths of Project 2000 were the development of skills, increased confidence in practice and the development of critical thinkers. Another advantage of Project 2000 found in a study done by Joyce 1998, cited by Donaldson (2003), was that students had more time to observe procedures.

The weaknesses of Project 2000 found that there was a lack in supervision in certain instances and negative experiences, due to staff animosity toward nursing students. Donaldson (2003) shares this view stating: “clinical staff reported that they were unprepared for the role” (Donaldson, 2003:26). Uncertainty about the role of staff existed and was a hindrance to positive supervised experiences for the students.

Other study results reported mixed opinions about whether or not to allow students to observe only, or if they should participate in care (Allan, 2009). It was suggested that students’ progress from observing to work under supervision and then independently. With the misconstrued ideas that existed about the supernumerary status, studies done by (Hyde and Brady, 2002) cited by Donaldson (2003) and supported by Allan (2009) revealed that in the clinical responsibility theme of the study, traditionally trained nurses were given more responsibility than the Project

2000 students'. Allan (2009) state that equally students find their supernumerary status problematic. It was believed that the traditionally trained nurses had more interest and motivation than their counterparts did. High supervision requirements contributed to uneven task distribution between traditionally trained nurses and Project 2000 students. Allan (2009) further concurred that senior nurses continue to expect that students are competent and no period of preceptorship when work started, is required. Pressure of work overload is a contributing factor in the level of supervision during busy periods.

A study conducted by Elcock (2006) report that supernumerary status is purely an administrative concept and that it made little difference to the students' role in practice. A common interpretation reported by Allan (2009) of supernumerary status was that students were to observe in practice, thus excluded from learning opportunities.

#### **2.4.1.2 Practice placements of nursing students**

Globally it is recognised that students' status remain supernumerary in the clinical setting. Discussions regarding the supernumerary status are supportive of the notion that students not to be accounted for as workforce in clinical setting. However, a common view shared is for the students to gain valuable and positive experiences in the clinical setting, students must be active participants in the setting. The South Hampton University position statements supports the view that "There must be an adequate number of appropriately qualified and experienced staff at the practice placement setting" and "the practice placement settings must provide a safe and supportive environment" according to the (HPC Standards of Education and Training Guidance, 2009) (Health Professionals Council, 2009). The above mentioned ensure that learning, teaching and supervision, were designed to encourage "safe and effective practice, independent learning and professional conduct" (Health Professionals Council, 2009.5:4). Research conducted by Chaun and Barnett (2012:192) in Malaysia stated, "A supportive clinical learning environment is important for development of nursing knowledge and skills" (Chaun & Barnett, 2012:192).

Research conducted by Bagglin and Rugg (2010) highlights that the method of 'learning by doing' is the crux of clinical placement. Bagglin and Rugg (2010) furthermore reported that placing problems within context critical thinking developed. In addition, recognition of the importance of this 'theory-practice' link, practice-based learning accrues academic credit in the UK nursing education, alongside classroom-based studies (Bagglin & Rugg, 2010).

In modern nursing, the importance of combining theory with practice in preparation for registration has become central to the nursing practice. As students focus on acquiring competence in skills in the clinical setting, a link exist with their confidence level. Students' unable to link theory and practice are left behind, sometimes forced to leave nursing. Bagglin and Rugg (2010) suggest that practice placement can improve student motivation and provide opportunities to master basic nursing procedures and techniques. Furthermore, "practice placement is the place to practice and prioritize the varied elements of the modern nursing role" (Bagglin & Rugg, 2010:146).

In addition, Houghton (2014) report that, professional socialisation and development of students' confidence, job satisfaction and preparedness for practice is achieved. However, Houghton (2014) further suggest that for students, a developmental process accompanies the progress through a hierarchical and sequential process. The anticipatory anxiety stage experienced by students as they prepare to enter their first ward experience is a momentous event reported by Houghton (2014). Students discuss their hopes and fears for what lies ahead. The fear of the unknown attributes to anticipatory anxiety. Houghton (2014) further report that it is evident in this phase, that students use their supernumerary status and mentorship as coping mechanisms. Participants responded that they believed that the mentor would have been the cornerstone of their practice placement.

In their first placement however, reality hit home, students realise that the clinical placement does not reflect reality. Students conform quickly to fit-in and cope with the reality of becoming a nurse. Learning the hospital culture and the ward routine, in essence, creates the smooth path toward the final goal, thus they are learning survival skills.

In the next phase of becoming a branch student, students' express excitement as 'real learning' commences. Houghton (2014) reported that the status transition that takes place, from supernumerary to roster allocated service, causes significant upset and unexpected pressure. Extra hours worked by students' causes tiredness and makes students quickly realise that they are experiencing the real world. The nature of the overwhelming transition well supported by numerous researchers (Bradby & Soothill, 1993; White, 1993; Jowett 1994; Gray 1999) resulted in shock and turmoil experienced by students. Expectations of independent working, planning

and managing care for their patients are expected. The move from relative protective status of supernumerary student to roster-allocated services forces students to develop faster.

The result of rapid development once students experience their first roster-allocated service placement, a realisation sets in, that it neither is possible nor desirable to hold on to their supernumerary status.

Houghton (2014) report that, students surrender all thoughts of participating in learning opportunities. With the realisation of embarking on their future careers, a difference in emotions is experienced, some welcoming and some fearful. It could be assumed that some students feel more ready to fulfil their role and a minority might be fearful of the loss of their role as student (Thomas, 2013). Student development, moving from supernumerary to roster allocated service, marks total surrender of their supernumerary status. Thomas (2013) further reported that those students that develop intuition, appeared more confident in their ability to take on their new role as they are aware that the end is nigh as a student.

#### **2.4.1.3 Impact of Supernumerary Status on Roles and Responsibilities**

Major (2010:16) reports that inconsistencies in health care provision existed but with the removal of students through supernumerary status, consistency in health care is regained as staff were no longer disrupted with their placement. The researcher assumes that with a lack in supernumerary status, a close connection exists between stress and confidence levels experienced with the transition from student to practicing nurse. Furthermore, students reported that the frequency and quality of the clinical facilitation was unsatisfactory. Additionally, they reported feelings of “unpreparedness and powerlessness” (Jeggels et al., 2014:17). Maitland (2012:8) supports this view by reporting on the desirability of "a period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviors and to continue on their journey of life-long learning” (Maitland, 2012). Allan (2009) is of the view that the supernumerary status impact can be either positive or negative. On the positive side, to use students as co-workers assists to get through the work. On the negative, the student learning affects the patient care (Allan, 2009). Elcock (2006) is of the view that if the benefits of supernumerary status are not being realised, as the quality of clinical learning experiences may be compromised, which is a concern for nursing education.

Students sacrifice learning needs to feel part of a team and continue with delegated tasks unsupervised.

Elcock (2006) reports, that the need for students to feel part of the team is very important. Acceptance was coupled to access to information and inclusion in discussions. This is synonymous with a good learning environment, however, in contrast non-acceptance can deny students access to information therefore they can miss learning opportunities.

## **2.4.2 Accessing Others Skills and Knowledge Appropriately**

### **2.4.2.1 Student Supervision Increases Student Confidence and Safe Clinical Practice**

In order for students to achieve the prescribed level of confidence, students need allocation to a designated mentor while in practice placement (Smith, 2012). Smith (2012) argued that the designated mentor would facilitate the student work-based learning. Thus, the mentor is the key to practice learning by different universities. Smith (2012) reports that the mentor is the arbiter and he or she plays a key role in protection of the student's supernumerary status. Henderson (2011) reports that interactions between staff and students therefore vary depending on the role. These include for instance mentor, preceptor, clinical guide, link-tutor, clinical facilitator, work-based educator, and clinical coordinator. The ward sister renders students free from employment obligations, as in the past and the direct control of labour.

From the researcher's viewpoint, the student supervision in the clinical setting is ineffectual due to the absence of suitable clinical facilitators the view supported by Coetzee (2014). The discontentedness of students with their clinical setting is further supported by research where it was indicated that neither educator nor professional nurse provided adequate clinical supervision to students during their clinical placements (Brammer, Croxon & Mabuda, 2008) cited by Coetzee (2014). Mentor support plays a significant role in ensuring that the student gains quality learning in the nursing practice (Elcock, 2006). The level of support diminishes over time as students gain autonomy and assume responsibility for routines. Repercussion of insufficient clinical supervision hampers the student professional's growth and development and therefore creates incompetent nurse practitioners with harmful effects to, not only themselves, but patients as well. Elcock (2006) suggests that in order to receive appropriate support, students should be on duty with their mentor or have another mentor delegated to the student, in the absence of their allocated mentor. However, qualitative and quantitative research

has been conducted internationally and nationally to describe the student experience of clinical support (Mabuda, 2008. Pillay & Mtshali, 2008). Not much literature exists however, on the nurse's role in student supervision. Nurse educators and professional nurses all have a common function in the clinical setting namely, the support of students (Vallant & Nevelle, 2006, cited by Coetzee (2014). A more supportive and encouraging attitude is developed by professional nurses once they understand that it is essential to develop and promote student learning (Andrews et al., 2006; Lillibridge, 2007 cited by Coetzee, 2014). Due to professional nurses being liable for student nurse support in the clinical setting, the support rendered is especially important as the professional nurse might be experiencing an excessive workload (Ehrenberg & Haggblom, 2007 cited by Coetzee, 2014).

An advantage related to collegial support and teamwork in the clinical setting enable student nurses to spend more time with the professional nurse because of a reduction in work due to extra pair of hands which enable engaging in valuable learning experiences (Carlson et al., 2010). Carlson et al., (2010) is of the view that support of student nurses in the learning environment is a substantial investment, not only for student nurses, but also for the future of nursing and must therefore be valued.

Pillay and Mtshali (2008) emphasise that the crux of clinical supervision is an agreement between the student and the supervisor. The agreement describes the amount of time of clinical supervision and the rules, objectives, roles, responsibilities and expectations throughout the student learning process. It is further stated by Quinn and Hughes (2007), that the contract (agreement) gives the students some control over the outcomes, methods and content that is stipulated in the curriculum. The University of Portland (2015) utilises a variety of clinical teaching roles to support students' clinical learning at a range of clinical sites. The University of Portland identifies the clinical faculty coordinator, clinical instructor, preceptor, clinical teacher and clinical teacher assistant as a clinical teaching team.

Pillay and Mtshali (2008) further state that the core of clinical supervision comprises various important issues such as the outcomes of clinical supervision achieved through the educational process. Therefore, it depicts the student skill, attitude and knowledge at the end stage of the learning process in order to accomplish competence.

Coetzee (2014) acknowledges the importance of clinical supervision, however she reports that in order to promote safe care practices, due to minimal clinical supervision, the immense

responsibility is with the nurse educators and the professional nurses to ensure that the students are competent and perform at a level relevant to their experience (Mabuda, 2008).

*The National strategic plan 2012/2016* outlined that students in a clinical facility must be accompanied or supervised by a facilitator/educator (National Strategic Plan: Nurse Education, Training and Practice, 2012). The South African Nursing Council in the guidelines for student accompaniment and supervision shares this view (SANC Regulations: Education and Training of Nurse and Midwife, 1985).

Students' develop realistic expectations of what they will gain from their mentors when mentors provide explanations. Mentors have knowledge and the aspect of knowledgeable link how students perceive their mentors as a practicing nurse (Gray, 1999). The role perceived by students of the mentor initially is one of a supporter, supervisor and assessor. With time, Gray (1999) reports that student views of the role of the mentor changed after several placements. With the role of supporter maintained, supervision was only important initially. As students become independent, the assessor was also associated to making a good impression through their involvement in student assessments.

The Australian Nursing and Midwifery Council (2005) stated that professional nurses contribute to the professional development of themselves and others (ANMC Code of Professional Conduct, 2005). Therefore, it requires the nursing staff to teach nurses in other categories such as students. The Canadian Nurses Association (2009) stated that nurses have to provide constructive feedback as required concerning competency (CNA Code of Ethics, 2009). It is reported by Henderson (2011) that nurses aware who were of their responsibility with regard to feedback, play an integral part in the establishment of clinical learning environments where all personnel engage in the development of others.

The role of the nurse educator was being unified and includes teaching, assessing and supervision of students in the clinical environment.

### **Educational support to students and nursing personnel**

Educators need to take their role in rendering educational support very seriously. A program that includes well-prepared preceptors will allow students to venture outside the ward routine for knowledge and in so doing, supervise and guide them in the clinical setting. (Meyer and Van Niekerk, 2008) cited in Coetzee (2014) support this view in stating that a strong and

supportive relationship with preceptors in the clinical learning environment will be required to achieve effective facilitation of learning. Portland University (2015) identified several roles and responsibilities of the preceptor: Preceptors should provide continuity of direct instruction, and supervision of students that is consistent with the students' learning needs and course objectives and outcomes. A further responsibility is to observe the student directly with clients. The preceptor is a professional role model, and must operate in line with the scope of practice of a registered nurse. They should also provide the student with support through questioning and advice, to ensure students' growth in clinical inquiry and in reflective practice through use of evidence-based practice.

The preceptor is also responsible for timely feedback to the clinical instructor about the students' performance and learning needs. The preceptor should notify the instructor promptly with any concerns regarding the student or client's safety and well-being. The preceptor further assists the student to understand the agency/unit goals, care-delivery system, procedures and client population. In addition, the preceptor should work with the client and staff to understand the role, capabilities and learning needs of the student. Finally, the preceptor should provide feedback to the unit manager about the impact of the student learner on the unit, the staff and the clients (Portland University, 2015).

### **Teaching independency and reflective thinking**

The professional nurse does not only have an informal role to play as clinical teacher as stipulated in R425 of the South African Nursing Council, but also they serve as a guidance counsellor and preceptor (Coetzee, 2014). The professional nurse in the clinical environment has an informal task of teaching students. This informal teaching role involves delegating tasks, leading and interaction, including giving demonstrations and to rectify and clarify some problems students encountered in their learning institution, to enable the student to continue with their practical experience. The traditional role of the student is of someone who starts out being dependent and who then is moved to independence due to the nurse educators who must support and empower students to solve problems and evaluate situations in their learning environment.

### **Facilitation of good practice**

Inadequate clinical supervision is a negligent act according to researchers such as Chapman and Orb, Meyer and Van Niekerk (2008). To ensure optimal learning students have to team up with a clinical supervisor that shares their practical knowledge with the student. Students can reflect

on clinical observations made, to see the purpose of practice situations. With the focus of some professional nurses sometimes on the patient's demands, students' are excluded from valuable learning experiences, as they are not engaged in the care of patient. The importance of student engagement in nursing care obliges professional nurses to facilitate learning during practice. Supporting this view were researchers such as Henderson, Newton, Billet and Ockerby (2009). Preceptors should keep a record of the skills that the students achieved, in order to limit the over-exposure of students to the same experiences. According to Coetzee (2014), this exposure is invaluable when partnered with a nurse educator that is competent and knowledgeable. If not, the learning opportunities in the clinical learning environment are more task-orientated and deep learning does not transpire.

#### **2.4.2.2 Educators View on Clinical Facilitation**

Although the various attempts made to reorganise and change nursing education, problems with nursing education still exist (Uys & Gwele, 2007)), the nursing profession stopped complaining. The problems are lack of correlation between theory and practice, multiple subject teaching and unavailability of tutors in the clinical setting. Uys and Gwele (2007) attribute the failure to solve these problems, to the educators criticising new approaches, as these would demand attention, effort and perseverance.

Educators have to be involved in the following facilitative and learning activities: student accompaniment, the use of alternative clinical placements, continuous evaluation, staff development programmes and the use of a variety of teaching strategies, especially focussing on active student participation. Researchers Uys and Gwele (2007) and Crotty (2010) shares the view that outdated nurse educators were among the identified factors hindering the attainment of programme objectives and outcomes (Uys & Gwele, 1995). The educators' workload was heavy and a fifty-two-hour workweek consisted only of one to three hours in clinical teaching in comparison with the junior educator staff that spent 3 to 4 hours in clinical teaching. Uys and Gwele (2007) report that to focus the programme, a review of basic standards and a local curriculum is required. Furthermore, these researchers suggest the restructuring of clinical teaching posts to equal the clinical instructor to the same status as a tutor. The preparation of students for professional practice and involvement in decision-making will be essential aspects. Clinical facilitation proves to be a rewarding experience and enhances student interest as reported by Henderson, Schoonbeek and Paterson (2011) concurred by O'Callagan (2003). A

result of facilitation was not only the analysis of own practice but also involved enhanced learning and professional practice, encouragement through progress and staying relevant in practice. Henderson et al (2011) and O'Callagan (2003) states that through the experience of facilitation, students appeared more motivated to learn in clinical placement. Students proved to be eager to learn in real-life situations, and nursing staff are more likely to be responsive and desire collaboration to assist students (Henderson et. al., 2011). Maturity of adult learners is a possible contributing factor.

In contrast, the positive effects of facilitation, many participants in O'Callagans' study reported feelings of being ill prepared for facilitation. Henderson et al (2011) support this view and state that the way in which nurses interact while they attend to the workload is instrumental to behaviours that facilitate learning as support is required to ensure staff is adequately prepared to interact with others. There was also a lack of support from management and the school of nursing. The feeling was exacerbated, findings of supernumerary status being demanding at times and adding to an extra workload to an existing busy workload. Pressure of taking responsibility for patients and students at the same time contributed to the findings. Researchers report that although students in tertiary programmes for nursing had a high level of theory, the application thereof in real-life situations, was problematic (O'Callagan, 2003).

The findings also revealed that, due to differing interpretations of the phrase 'supernumerary status', this had implications for students as the students were seen as extra help while the students were merely there to observe (Allan, 2011). With conflicting demands also placed on the ward sisters, the value of their experiences to provide an environment that was conducive to learning for students was also questionable. They were not always able to facilitate students but allocated students to staff. While Hughes (2015) report that students expected facilitation to be in line with the facilitators teaching role, students felt lost, the facilitator cannot always teach directly. A number of participants reported stress and frustration associated with interpretation of supernumerary status. Some positive aspects of facilitation reported were self-satisfaction and increased internal motivation.

Franklin (2013) identified different models of clinical supervision, however, challenges regarding clear guidance and direction still exist according to Health Workforce Australia. Two of the five identified models reported to be the most supportive in the clinical learning environment for students were the facilitator-preceptor and dedicated-education unit models

of clinical supervision (Franklin, 2013). Atkins (1995) reported that the presence of the mentor was invaluable in reducing the anxiety of students. Supporting students, facilitating learning, learning through students, managing conflicting roles and responsibilities and working in partnership were key activities to assist mentees in the clinical environment. Key mentoring issues identified by Atkins (1995) were that mentors needed formal preparation for their role as mentors and that is resource-intensive. Tension caused by role-modelling and mentoring would be ameliorated by further personal and professional learning and development of the mentor.

Franklin (2015) further reports that Health workforce Australia identified a shortfall of nursing jobs and an ageing population in the nursing profession due to high retirement rates expected until 2025. In addition, urging the Healthcare workers and Educators to foster and maintain a clinical environment that will recruit nursing students and retain all levels of nurses. Due to nursing being a discipline where the minimum standard of competency is required to gain registration, the lack of competency is evident in the clinical environment. Clinical placements provide the students with an opportunity to link theory to practice and to familiarise themselves with the clinical practice environment. Furthermore, the clinical placement provides the student with real-life experiences to develop knowledge, skill and a professional attitude. However, Franklin (2013) emphasises that the cornerstone of successful clinical placement is a high quality of nursing student supervision.

The concept traced back to Florence Nightingale, who instructed that student nurses had to train under the direct supervision of experienced nurses, who 'were trained to train'. With the array of clinical supervision models, ambiguity and confusion is brought about as to which model best support students in the clinical learning environment (Franklin, 2013). Examples of these models are: the cluster model (Bourgeois, Drayton & Brown, 2011); the growth and support model (Butterworth & Faugier, 1992); Heron's intervention analysis (Heron, 1989); integrative approach (Hawkins & Shoheit, 1989); the proctor model and the 4S model (Waskett, 2009).

Due to lack of information on the impact of high quality clinical supervision, little evidence exists within literature that evaluates the effectiveness of clinical supervision model currently or whether a particular clinical supervision model is better than the other to achieve quality in learning outcomes. Sedgewick and Harris (2012) report that the clinical facilitation model that exist in South Africa is inadequate possibly due to shortages of nurse educators to

supervise nursing students in the clinical setting. In comparison, Australia clinical facilitation is achieved through preceptorship, clinical instruction and a combined method where nurse educators, clinical instructors and clinical preceptors play a role in clinical teaching of students (Franklin, 2013).

**Table 2.1: Health Workforce Australia (HWA, 2010) clinical supervision models adapted by researcher in attempt to clarify different models**

<b><u>Components of model:</u></b>
<u>Preceptor</u> : The most commonly used clinical supervision 1:1 model where a students are assigned to a registered nurse who is a known as the preceptor. The student works alongside the preceptor on a day-to-day basis to provide direct and indirect supervision and undertakes formative and summative assessments.
<u>Facilitation/supervision</u> : A 1:6 or 1:8 model where a registered nurse directly and indirectly supervises a group of students. Facilitators are either University employed or hospital employed staff and undertake both summative and formative assessments.
<u>Facilitation/preceptor</u> : A combination of the preceptor and facilitation/supervision model where a students are allocated to a registered nurse as preceptor and the facilitator undertakes group supervision of 1:8 or more.
<u>Dedicated education unit</u> : A combined model of the preceptor and facilitator model with the added component that there is a partnership between the health service and University and there is clinical liaison nurse, better known as a ‘Nurse Educator’ that provides the link to the University.
<u>Mentor</u> : A model that is similar to the preceptor model but less commonly used in undergraduate clinical education as the clinical supervision is more often than not, indirect. The mentor model involves a longer-term relationship between the student and the registered nurse.

Franklin (2013) theorises that it is undeniable that the value and the importance of good quality supervision cannot be underestimated to ensure that students are supported adequately and prepared for the transition to graduate nurses.

From the literature, it is determined that the facilitator model is favoured over the preceptor model due to increasing clinical workloads and lack of preceptor training.

Franklin (2013) reports that the education unit model is best to meet all the aims and needs of Health Workforce Australia, preceptors, facilitators, education and healthcare providers and the students. In addition, evidence suggests that the dedicated education unit model and facilitator model enable students to practice skills and procedures in a supportive clinical environment. Graduate nurses who are critical thinkers and competent, are outcomes of this model. Franklin (2013) reports that Health Workforce Australia (2010) compared clinical supervision models using researchers such as Bourgeois (2011), Butterworth (1992), Heron (1989) and Hawkin and Shohet (1989) to name a few examples. The models suggests that the dedicated education unit model offer more support to the nursing students. With the use of clinical facilitators, there is a need to examine closely who is the 'best' facilitator, either sessional, academic lecturers or trained facilitators from health care facilities in which undergraduate nursing students undertake their clinical placements. Another reason is the models ability to increase the student capacity. This is in line with the growing concerns of the ageing nursing population. It is of importance that with the increase in the number of students entering nursing, to optimise ongoing support and education in the clinical environment to its fullest. Franklin (2013) suggests that research concerning the different models effectiveness could help support, recruit and retain nursing students.

#### **2.4.2.3 Facilitation and Educators' Challenges**

Cambier, Dejonge, Kelley, McDermitt, Miller and Riddlle (2013) report that as change agents, nurse educators must bridge the gap between academic preparation of students, and nursing practice. Educators face many role challenges among them, accountability for finding solutions that are effective and realistic. Cambier et al. (2013) stated that there is reluctance among nurse educators to initiate change desperately needed in education. One of the major challenges of the facilitation of learning is the measurement of desired standards. Due to the complexity of teaching strategies, outcomes and student learning styles, the task is not easy. Challenges exist among educators to develop programmes that are multidimensional and that incorporate a variety of teaching strategies utilising Student Learning Outcomes (SLO) to measure success of the programme. Accreditation bodies focus more on SLO and less on the teaching input and curriculum. Society, professional organisations and health care organisations demand wellprepared nurses (Cambier et al, 2013). The other demands are that the outcomes for the

nursing profession are met, including bridging the gap between the classroom and the real world, which is the motivation behind the clinical rotations in nursing education (Cambier et al., 2013, cited Kolb, 1984). This bridges knowing-what and knowing-how. Experiential learning used more frequently in the curriculum, the emphasis placed on how behaviour affects the learning process, rather than the cognitive process. Thus, educators must demonstrate accountability to the profession and to the students by ensuring that what they say is heard. Cambier et al. (2013) believes that SLO is the key ingredient and suggest that evidence and research activities, should be used by educators to support measurable outcomes.

With the rapidly changing healthcare system, a need to stay relevant adds to the challenge of content increase. Cambier et al. (2013) stated that overcrowded curricula are one of the challenges facing nursing students today. Due to all content viewed as necessary, it has become unclear what content to include and what to be discarded. It is suggested that nurse educators should rethink their current ways of developing the curriculum and focus on student-centred learning rather than teacher-centred curriculum design (Cambier et al., 2013). To tie theory into practice, educators need to design a course that is in line with the core objectives of the department of nursing and the present related theoretical information. “Educators can do so by challenging their long-held traditions” (Cambier et al., 2013:8) and design a curriculum that is flexible, evidence-based, responsive to student needs and one that integrates technology. The focus of the curriculum is no longer on content coverage but on the development of analytical thinking skills and critical thinking skills. Integration of web-based classrooms and online classes can benefit the faculty and students through provision of self-paced, active involvement and increased learner attention. Thus, nursing education universities should pair with the nursing leaders in the setting that assures that the curriculum is innovative and relevant (Cambier et al., 2013).

Nurse educators face challenges associated with curriculum evaluation due to healthcare policies that are also rapidly changing and the need to keep up with these changes. An influx of novice nurse educators to replace retired faculties has left a gap in the depth and expertise of the curriculum process and evaluation (Cambier et al., 2013). Workload and limited resources contribute to educators’ challenges in curriculum evaluation. Thus, the educator must look for new and innovative ways to deliver the needed content to avoid pitfalls of stagnation. It is amenable that the role of nurse educators in the 21<sup>st</sup> century is rapidly changing and nursing

itself is undergoing change. It is vital, therefore, for the nurse educators of today to facilitate learning through the engagement of students in the learning process (Cambier et al., 2013).

Positive learning approaches that vary in classrooms and in virtual environments should be included.

### **2.4.3 Enhancing Leadership Skills**

Buckwell-Nutt (2014) assert that varying components are essential to the development of leadership awareness and adult learning principles, including communication skills and conflict resolution, have been recognised by universities. A multifaceted and collaborative approach is required to drive the improvement of nursing leadership from all stakeholders, service providers and educators.

### **2.4.4 Student Attributes**

Socialisation defined, is the process whereby individuals acquire the distinct behaviour, attitude and values of a particular profession Thomas (2013). Professional socialisation is a complex process where an individual acquires skill, knowledge and an occupational identity that is characteristic of that profession. Furthermore, it involves the internalisation of the values and norms into the person's own behaviour and self-concept Zashenas (2014).

Study conducted by Thomas (2013) hypothesised that socialisation exists in three phases, identified as transition to task orientation, attachment to significant others in the work milieu, and internalisation of professional values. Although these phases overlap, it is a sequential process similar to childhood socialisation.

According to Thomas (2013), Jarvis (1983), report that socialisation brought into an occupation becomes a fundamental part of secondary socialisation that represents a significant process known as tertiary socialisation. This is evident in later research studies regarding the socialisation of nurses, from a range of students undertaking a traditional apprentice-type curriculum model to the introduction of Project 2000 Diploma in Higher Education and an increasing number of degree programmes. It is further reported by Thomas (2013) that researchers Elkan and Robinson reported that investigations have sought outcomes in the production of knowledgeable doers with the move into Higher Education or in tackling subjects that may have impeded implementation of Project 2000 (Thomas, 2013).

In addition, there have also been investigations that have evaluated the effectiveness of supernumerary status on socialisation for example Spouse (2000) who concurs with the notion that student aims can be achieved through supernumerary status and effective support from knowledgeable practitioners. According to Thomas (2013), strong themes emerged from research done by Philpin where the nature of socialisation actually related to the work context in which it was experienced. Project 2000 nurses experienced the processes of socialisation in high dependency areas such as theatres to be tougher. In contrast, the socialisation process was more satisfactory and communication between the student nurses and the traditional staff members more effective in medical and geriatric care wards. The acknowledgement of the students' interpersonal skills and increased knowledge of biological and social sciences was beneficial.

#### **2.4.5 Staff Beliefs**

Discontent existed between students and qualified staff due to the work that students were required to do reported in a study on how student nurses' supernumerary status affected the way they think about nursing (Allan, 2009). The view qualified staff have is that students need to be able to deliver bedside care as this was the skill they were taught as students. However, Allan (2009) reports that nurses were often unable to deliver bedside care because of the busy nature of the clinical areas, therefore students did not view this care rendered. In light of the above staff members were aware of the difference that existed between what they encouraged students to learn and what they themselves practised.

O'Connor (2007) report that the HCAs' role was key for students to understand what is viewed as nursing. Students aspired to the more technical and organisational roles when they observed the health care assistants delivering hands-on care and, while qualified nurses were only involved in the more technical aspects of care and the organisation of the ward. This difference between what qualified nurses actually do (drugs and coordinating ward work) (Mooney, 2007), and what they expected students to do (deliver bedside care) was recognised by participants across the sites (Allan, 2009). The findings supported by a focus group exchange conducted by Allan (2009), participants responded as follow:

*Because some students don't perceive doing nursing care as nursing, but the healthcare assistants do so much work that we as students used to do, they don't see themselves as learning anymore.*

## **2.5 Conclusion**

This chapter dealt with reviewed literature and themes and sub-themes that emerged from literature. These include: supernumerary status, accessing others skills, student supervision, educators view on clinical facilitation, facilitation and education, enhancing leadership skills, student attributes and staff believes. The next chapter will outline the research methodology.

## CHAPTER 3

### RESEARCH METHODOLOGY

#### 3.1 Introduction

Terre Blanche, Durrheim and Painter (1999) define research methodology as the manner in which a researcher goes about studying what s/he believes can be learnt. Burns and Grove (2009) refer to the methodology as the plan to conduct the research study.

This chapter presents the research design and methods used to guide the study. In this study the research paradigm and approach followed, study design, research setting, study population, sampling, data collection, validity, reliability and trustworthiness, data analysis, ethical considerations will be presented.

#### 3.2 Research Paradigm

A paradigm is defined as a model or framework for observation and understanding, which shapes both what we see and how we understand it (Babbie, 2008). Authors Guba, Lincoln, and Plack (2005) argue that a paradigm is a set of basic beliefs that represents a worldview. This research study followed a positivist paradigm, also referred to as logical positivism. The positivist researcher uses statistical analysis to measure phenomena and rely on quantitative data to determine statistical relationships among variables. The scientific approach involves the use of orderly disciplined procedures with tight control over the research situation (Polit & Beck, 2008).

The positivist paradigm is closely associated with the quantitative research approach. Quantitative research is a formal, objective, rigorous, systematic process for generating new information, therefore its use in this study (Burns & Grove, 2007).

#### 3.3 Research Approach

A quantitative approach defined by Burns and Grove (2005) is a formal, objective, systematic process in which numerical data used to accumulate information about a phenomenon. Babbie (2008) suggests that the quantitative approach makes a distinction between categories of numerical data. The researcher selected the quantitative approach to assist with statistical analysis of the study. The data were used objectively to explain the phenomena, which were the

students' perceptions of their roles and responsibilities in the clinical setting at a selected nursing education institute (NEI) in KwaZulu-Natal.

### **3.4 Research Design**

The research design is defined as the overall plan of collecting information on the question being studied (Polit & Beck, 2008). Mouton (2006) suggests that the research design as a set of guidelines must be followed to address a research problem. The research design focusses on the researcher's perspective for the purpose of the research study (Babbie, 2008).

A quantitative, non-experimental, explorative design was selected. Exploratory designs are used with the aim of establishing facts by gathering data to determine whether or not patterns exist between the data sets collected (Mouton, 2006).

In addition, exploratory research investigates the full nature of the phenomenon, the manner in which it is presented, and other factors related to it (Polit & Beck, 2008).

The researcher of the study deemed exploratory design therefore to be appropriate to explore students' perceptions regarding their roles and responsibilities in the clinical setting at a selected nursing education institute (NEI) in KwaZulu-Natal. To the best of the researchers' knowledge, no study of this nature was conducted at a KwaZulu-Natal Higher Education Institution. More importantly, the study intended to explore and uncover the perceptions of student nurses regarding roles and responsibilities in their clinical setting.

### **3.5 Research Setting**

The research setting is defined as a physical location and condition in which the data collection takes place (Polit & Beck, 2008).

The study was conducted at a Private Nursing College, which is situated in Durban, South Africa. The study included the programme R683 bridging course. Entry to the setting was established through the first and second year nursing students' facilitators, and the principal of the College.

### **3.6 Study Population**

The population according to Brink (2012) is defined as the entire group of persons or objects that are of interest to the researcher, in other words those who meet the criteria that the

researcher is interested in studying. Burns and Grove (2005) describe population as the whole set of individuals or elements that meet the researcher's set criteria of selection.

For the purpose of this study, the target population included the first year and second year nursing students currently registered at a Private Nursing College in the program R683 Bridging course. The reason for the researcher selecting the first and second year group was the easy accessibility to the population. Furthermore, they fulfilled the characteristics of interest of the research as they were exposed to clinical settings as part of their practical experience. As a result, first and second year students were considered as the target population since the results of this study will be relevant and applicable to them. The (N=30) number of students in the first-year group, second year group (N=30). A repeat group existed that consisted of (N=40) students in either the first or second year. These students either did not complete the amount of required hours or did not meet the examination criteria of the school.

The total number of students in the two separate year groups were (N=100).

### **3.7 Sampling and Sample Size**

Polit and Beck (2008), (Brink, 2006) define sampling as the process of selecting elements within a population that represent the entire population so that inferences about the population can be made. The researcher selected subjects who are representative of the population being studied. For the quantitative aspect, a convenience, nonprobability sampling technique was utilised to select a sample. Convenience sampling was used as the participants were easy to reach (relative to proximity), accessibility and availability was easy. In this type of sampling, participants were selected based on the knowledge of the population. This method is most useful due to representativeness and usefulness in this study, as the researcher chose the elements of the study that were available and ready in the right place at the right time during the study period (Brink, 2006). The sample size in this study was one hundred (100) nursing students. This was the total number of nursing students ranging from first to second year at a Private Nursing College included in the sample for this study.

According to Polit and Beck (2008), the inclusion criteria are the list of characteristics that a subject must have in order to be eligible to participate in the study. In this study the researcher made use of the following inclusion criteria: nursing students willing to participate who are in the first or second year of study, student nurses that were registered for the Bridging Programme R683 at a Private Nursing College in 2016.

### **3.8 Inclusions and exclusions**

The exclusion criteria were characteristics that eliminate a subject from being eligible to participate in a study (Polit & Beck, 2008). In this study, the exclusion criteria consisted of: the nursing students unwilling to participate in the research study.

### **3.9 Research Instrument**

Quantitative researchers collect empirical evidence according to a formulated plan, using a structured instrument to gather the required information (Polit & Beck, 2008). The research instrument is the instrument that would yield the most significant information that is reliable and will yield valid information. Maree (2008) defines reliability as the extent to which a measuring instrument is repeatable and consistent. This means that the instrument, if used at different times, or administered to different subjects from the same population, should yield similar findings. Reliability of the instrument was ensured by undertaking the test-retest activity.

The researcher used a self-reported questionnaire for the purpose. The self-report questionnaire contained items to solicit appropriate information for analysis using existing literature that relates to the research topic. The questionnaire was assessed by the supervisor and to comprise of 40 questions to achieve the aims and objectives of this research study. The questionnaire was handed out to three nursing students that were not participants in the main study.

This study was initiated by collecting quantitative data from participants, using a self-administered questionnaire developed by the researcher using relevant literature (See Appendix 1). Items from the questionnaires were centred on the objectives of the study. A five point Likert scale was used to rate the views of participants ranging from 'strongly agree', 'agree', 'neutral', 'disagree' to 'strongly disagree'. The Likert scale further calculates the average index score for those agreeing on an individual statement. Thus, the Likert scale includes several declarative statements followed by response categories after each statement (Brink et al., 2008). Respondents indicate the degree to which they agree or disagree. A numerical value was assigned to each response category, example 1-5 (Brink et al., 2008).

### 3.10 Validity and Reliability of the Instrument

#### 3.10.1 Validity

According to Polit and Beck (2008), the validity of the research instrument is determined by the degree to which it accurately measures what it is intended to measure, in the context in which the instrument is applied. Authors Long, Johnson, Graneheim and Lundman (2004), suggest that validity and reliability serve as a means of ensuring the rigour of the research process and research findings. Content and construct validity was ensured through comparison of items in the data collection tools against the study objectives and concepts in the conceptual framework. This ensured that all the elements included in the research study were measured. The instrument used related to the objectives of this study. The researcher submitted the data collection tools for review and critique to a panel of experts in research and nursing education and thereafter modifying them according to their feedback.

**Table 3.1: Content Validity of Instrument**

<b>Research Objectives</b>	<b>Theoretical Framework</b>	<b>Questionnaire Items</b>
<b>1. To explore students' perceptions of their roles and responsibilities in the clinical setting</b>	Concrete experience, abstract conceptualisation and active experimentation	Q 6 – Q25
<b>2. To explore students' perceptions of challenges in the clinical setting</b>	Reflective observation and abstract conceptualisation	Q26 – Q34
<b>3. To explore support of students in the clinical setting from facilitators, mentors, supervisors, preceptors and educators</b>	Reflective observation and abstract conceptualisation	Q35 – Q40

### **3.10.2 Reliability**

According to Brink (2010) reliability of the research instrument is the degree to which the instrument can be depended upon to yield consistent results if used repeatedly. The Reliability in the study depended on accurately reporting what the researcher claims to report. Author Maree (2008) support Brinks' definition by stating that reliability is the extent to which a measuring instrument is repeatable and consistent. Therefore, the instrument, if used at different times, or administered to different subjects from the same population, will yield similar findings.

Researcher piloted the instrument, as it was used in different contexts in research studies. The aim of it was to fit the purpose of this study. A pilot study is a smaller version of a proposed study conducted to develop and/or refine the methodology, such as the treatment, instrument, or data collection process (Burns and Grove, 2005). A pilot study is also referred to as a preliminary study as this is a small-scale study conducted prior to the main study on a limited number of subjects from the population at hand. Its purpose is to investigate the feasibility of the proposed study and to detect possible flaws in the data-collection instruments, such as ambiguous instructions or wording, and inadequate time limits (Brink, 2010).

In the pilot study the reliability of the instrument was measured by conducting, a re-test for reliability. Methods such as Cronbach's alpha determines the internal consistency of the instrument's reliability, certain items can be removed to improve the Chronbach alpha test score when this method is utilised. According to Polit and Beck (2012), the acceptable score in the Cronbach's alpha test is 0.70.

### **3.11 Data Collection Process**

Quantitative researchers collect empirical evidence according to a formulated plan, using a structured instrument to gather the required information (Polit & Beck, 2008). The data collection process is, then, the systematic gathering and measurement of research questions.

Data collection commenced only after ethical clearance was granted by the University of KwaZulu-Natal (UKZN), Faculty of Health Sciences Research and the Ethics Committee.

A self-reported questionnaire is a document containing questions and other types of items designed to solicit information appropriate for analysis (Babbie, 2008). The researcher utilised existing literature related to topic. Aims and objectives of the research guided the researcher.

The questionnaire comprised forty questions. The respondents used a Likert scale to rate the answers through categories. The value of this format was the unambiguous ordinal presentation of response categories (Babbie, 2008)

To gain access to the participants a permission letter requesting permission from the college principal was obtained. The first and second year nursing students from the college were included in the study. Lecture timetables were consulted to identify the days that the registered nursing students would be on campus.

Prior arrangements were made with lecturers to have access to students in their free time. Students were invited to participate in the study after the purpose of the study was carefully explained. The researcher distributed the questionnaires among the participants. The data collection in the study took place over a 4-day period. The data was collected in September/October 2016. The questionnaires were distributed by the researcher and collected by researcher at DT Nursing College.

### **3.12 Data Analysis**

Brink (2010) defines data analysis as categorising, ordering, manipulating and summarising the data and describing them in meaningful terms. In addition, the conversion and condensing of collected data will assist further to achieve a meaningful report (Brink, 2010).

In this study the quantitative data from the questionnaire was coded and entered for analysis and organisation of data utilizing the SPSS Version 24 for Windows software. Data analyses using descriptive statistics, percentages and graphs were used to summarise data in this study. Numerical data was summarised. Measures of central tendencies and dispersion such as mean, median and standard deviation of responses were used to interpret and compare responses. Tables and figures were used to present data obtained from the application of the SPSS Version 24. Crossing tabulation using Chi-squared test for association of responses in the various domains and respondents' socio-demographic variables revealed no association.

### **3.13 Ethical Considerations**

Brink (2006) states that ethical consideration is crucial in research and this aims to protect the rights of participants, avoid harm to participants' and to maintain honesty in the research. Nursing research requires a range of abilities. Some of these abilities do not only include

expertise and diligence but honesty and integrity as well, therefore, ethical research is essential to produce sound evidence-based practice for nursing

The researcher adhered to the three fundamental ethical principles that guide researchers: respect for persons, beneficence and justice. The principles are based on the human rights, claims and demands that have been justified in the eyes of an individual or group of individuals, that need to be protected in the research (Burns and Grove, 2009). These are the right to self determination, to privacy, anonymity and confidentiality, fair treatment and protection from discomfort and harm.

**Permission:** Prior to the data collection, the researcher submitted a research proposal to Ethics Committee that granted ethical clearance to conduct the study. The researcher in addition obtained consent from the principal at a Private Nursing College before the study commenced.

**Right to self-determination:** is based on, ethical principle of respect for persons. The prospective participants were asked to acknowledge their voluntary participation, and it was made clear that they had the right to withdraw from the study at any time without penalty (Burns and Grove, 2009).

**Informed Consent:** Individual consent was obtained from participants through written and signed informed-consent forms.

**Voluntary participation:** Participants' were informed of the freedom of withdrawal from the study at any time. The researcher explained to participants that the research study carried no, physical, psychological, social or legal risks.

**Beneficence:** There were no direct benefits from respondents' participation either, but the information obtained could be used to improve nursing education in the country.

**The right to privacy:** This is described as the right of an individual to determine the time and extent under which private information such as beliefs and opinions are shared with or withheld from others (Burns and Grove, 2009). To protect the privacy of the participants in this study the researcher upheld the following ethical principles:

**Anonymity:** was achieved by protecting the participants' identity. Questionnaires remained anonymous since no names appeared on the questionnaires that could identify respondents.

**Confidentiality:** The data obtained from this study would only be accessible to the researcher, and used solely for the purpose of this research project.

### **3.14 Data storage**

Data that was collected, will be stored safely for a period up to five (5) years by the supervisor in the Nursing discipline at the University of KwaZulu-Natal and thereafter it will be destroyed. The software as well as the hardware was handed in to the university upon completion of the research for the purpose of disposal. According to the institutional policy, research data will be destroyed by means of shredding. Memory sticks will be physically destroyed, and utilized electronic data will be deleted from the hard drive. The analysed data which is saved on computer will be password protected as a security measure and only the researcher will have access to the password.

### **3.15 Data dissemination**

Research findings were presented in the form of a dissertation. Names of the participants and the institution will be protected during dissemination. Findings from the study will also be published in an accredited journal.

### **3.16 Conclusion**

This chapter covered the research methodology where themes and sub-themes that covered research paradigm, research approach, design, research setting, study population, sampling and sample size, validity and reliability, reliability, research instrument, data collection process, analysis, ethical considerations, data storage and data dissemination were discussed.

## CHAPTER 4

### ANALYSIS AND PRESENTATION OF RESULTS

#### 4.1 Introduction

This chapter presents the analysis and interprets the results of the study. The purpose of the study was to explore the students' perceptions of their roles and responsibilities in the clinical setting at a selected nursing education institute (NEI) in KwaZulu-Natal. Data collection was done using a questionnaire that was distributed among participants. The results of the study are presented in tables and figures.

Analysis of the data was done using the Statistical Package of Social Sciences, Version 24 (SPSS 24). Analyses of findings were framed based on the positivist paradigm for interpretation. Descriptive statistics were utilised and included: frequencies, means, standard deviations and percentages to describe the variables. Cross-tabulation and the Chi-square test were used to measure the extent of variables relationships.

In this study, there were four sub domains: (1) roles and responsibilities toward nursing care; (2) roles and responsibilities toward learning; (3) challenges in the clinical setting and; 4) support in the clinical setting.

#### 4.2 Sample Realisation and Response Rate

The population of the study consisted of a hundred (100) students. Seventy-seven (77) questionnaires were completed and returned, representing a 77% response rate. These were included in the final analysis of the results.

#### 4.3 Socio-Demographic Data

The demographic data included gender, age, level of study and the type of accommodation of respondents. Table 4.1 presents an overview of the participants' socio-demographic characteristics.

**Table 4.1: Socio-Demographic characteristics of respondents**

Variable	Variable Specification	Frequency (n)	Percentage (%)
<b>Gender</b>	Male	9	11.7
	Female	68	88.3
<b>Age</b>	18-24	44	57.1
	25-30	16	20.8
	31+	17	22.8
<b>Study Level</b>	1 <sup>st</sup> year	18	23.4
	2 <sup>nd</sup> year	59	76.6
<b>Accommodation</b>	College residence	10	13
	Home with parents	67	87

A total of (n=77) respondents returned and completed the questionnaire. Majority of respondents were females (88.3%; n=68) compared to a minority of respondents (11.7%, n=9) who were males.

The minimum age considered in the study was 18 years and the maximum age included was 31 years and above. The majority of respondents, (57.1%; n=44), were within the 18-24-year range. The remaining respondents' age group were almost equally distributed and ranged between age group of 25-30 years, (20.8%, n=16) and 31 years and above, (22.8%, n=17).

The results of the study also indicated that the majority of respondents were in their second year of study, (76.6%; n= 59), while minority of the respondents, (23.4%; n=18), were in their first year of study.

Analysis of data gathered on respondents' place of accommodation further revealed that the majority of respondents, (87%; n=67), lived at home with their parents while the minority of the respondents, (13%; n=10), stayed in a college residence.

#### **4.4 Description of Respondents' Perceptions of Their Roles and Responsibilities in the Clinical Setting**

The responses with regard to the roles and responsibilities in the clinical setting were in four domains: 1) respondents' perception regarding their roles and responsibilities in the clinical setting to nursing care; 2) respondents' perceptions regarding their learning; 3) respondents'

perception regarding the challenges in the clinical setting and; 4) the respondents' perceptions regarding support in the clinical setting.

#### 4.4.1 Roles and Responsibilities in the Clinical Setting: Nursing Care

Thirteen items were used to measure the participants' perceptions regarding their roles and responsibilities towards nursing care in the clinical setting. The participants' levels of agreement and disagreement are recorded in Table 4.2.

**Table 4. 2: Roles and responsibilities in the clinical setting: Nursing Care**

Variable Specification	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I maintain client confidentiality in the clinical setting	77.9% (n=60)	14.3% (n=11)	7.8% (n=6)	0% (n=0)	0% (n=0)
As a nursing student I actively promote the highest level of moral and ethical principles and accept responsibility for my actions	53.2% (n=41)	39% (n=30)	6.5% (n=5)	0% (n=0)	1.3% (n=1)
As nursing student I can take appropriate action to ensure safety of clients, self and others	70.1% (n=54)	22.1% (n=17)	7.8% (n=6)	0% (n=0)	0% (n=0)
As student I communicate truthful, timely and accurate	58.4% (n=45)	33% (n=26)	7.8% (n=6)	0% (n=0)	0% (n=0)
I am part of the ward staff compliment	35.1% (n=27)	28.6% (n=22)	23.4% (n=18)	10.4% (n=8)	2.6% (n=2)
I am merely an observer in the clinical setting	39% (n=30)	40.3% (n=31)	14.3% (n=11)	2.6% (n=2)	3.9% (n=3)
I participate in ward work under supervision of a registered nurse	55.8% (n=43)	24.7% (n=19)	14.3% (n=11)	2.6% (n=2)	2.6% (n=2)
I am treated as a visitor in the ward	6.5% (n=5)	18.2% (n=14)	19.5% (n=15)	27.3% (n=21)	28.6% (n=22)
I participate in clinical activities without any supervision	10.4% (n=8)	9.1% (n=7)	22.1% (n=17)	29.9% (n=23)	28.6% (n=22)
I am able to identify clients' needs accurately	44.2% (n=34)	35.1% (n=27)	15.6% (n=12)	3.9% (n=3)	1.3% (n=1)
I am held accountable for the quality of care provided within the established objectives	33.8% (n=26)	33.8% (n=26)	40.3% (n=31)	24.7% (n=19)	1.3% (n=1)
Students are given the opportunity to become familiar with the clinical setting policies, procedures and protocols	29.9% (n=23)	36.4% (n=28)	23.4% (n=18)	5.2% (n=4)	5.2% (n=4)
I am able to collect relevant information from the client to identify clients' needs	44.2% (n=34)	35.1% (n=27)	15.6% (n=12)	3.9% (n=3)	1.3% (n=1)

Table 4.2 shows that the majority of respondents (77.9%; n=60) strongly agreed and a further significant proportion (14.3%; n=11) agreed that they maintained client confidentiality at the clinical setting as opposed to (7.8%; n=6) who were neutral. The mean score was 4.70.

Findings of this study reflect that more than half of the respondents strongly agreed (53.2%; n=41) and (39%; n=30) agreed that they promote the moral and ethical principles of nursing care and accept accountability for their actions. However, a portion of the respondents remained neutral (6.5%; n=5) while a minority strongly disagreed at (1.3%; n=1), with a mean score of 4.43.

Similarly, the majority of respondents strongly agreed (70.1%; n=54) and (22.1%; n=17) agreed that they were able to take appropriate action to ensure client safety, their own safety and the safety of others, compared to (7.8%; n=6) of who were neutral with a mean score of 4.623.

Again, more than half of the respondents strongly agreed (58.4%; n=45) and (33%; n=26) agreed that they communicate truthfully, timeously and accurately as opposed to (7.8%; n=6) who remained neutral. The mean score was 4.50.

When respondents were asked what their perceptions were about being part of the ward staff compliment, findings show that the majority of respondents strongly agreed (35.1%; n=27) and a (28.6%; n=22) agreed. While a significant proportion (23.4%; n=18) remained neutral, about a tenth (10.4%; n=8) of the respondents disagreed and (2.6%; n=2) of the respondents' strongly disagreed. The mean score was 3.83.

Almost the same proportion of respondents (40.3%; n=31) agreed and strongly agreed (39%; n=30) that they are merely observers in the clinical setting as opposed to (14.3%; n=11) who were neutral. The minority of respondents' (3.9%; n=3) strongly disagreed and disagreed (2.6%; n=2) they were mere observers in the clinical settings, with a mean of 4.07.

More than half of the respondents strongly agreed (55.8%; n=43) and (24.7%; n=19) agreed that they participate in ward work under the supervision of a registered nurse. From the remainder of the respondents that same proportion (2.6%; n=11) strongly disagreed and agreed to the statement, while (14.3%; n=11) of the respondents remained neutral with a mean score of 4.28.

Likewise, findings from the data analysis show nearly equal proportions of the respondents strongly disagreed (28.6%; n=22) and disagreed (27.3%; n=21) that they were treated as visitors

in the ward, whilst a significant proportion of (19.5%; n=15) were neutral. The minority however, agreed at (18.2%; n=14) and strongly agreed at (6.5%) that they were treated as visitors in the ward. The mean score was 2.46.

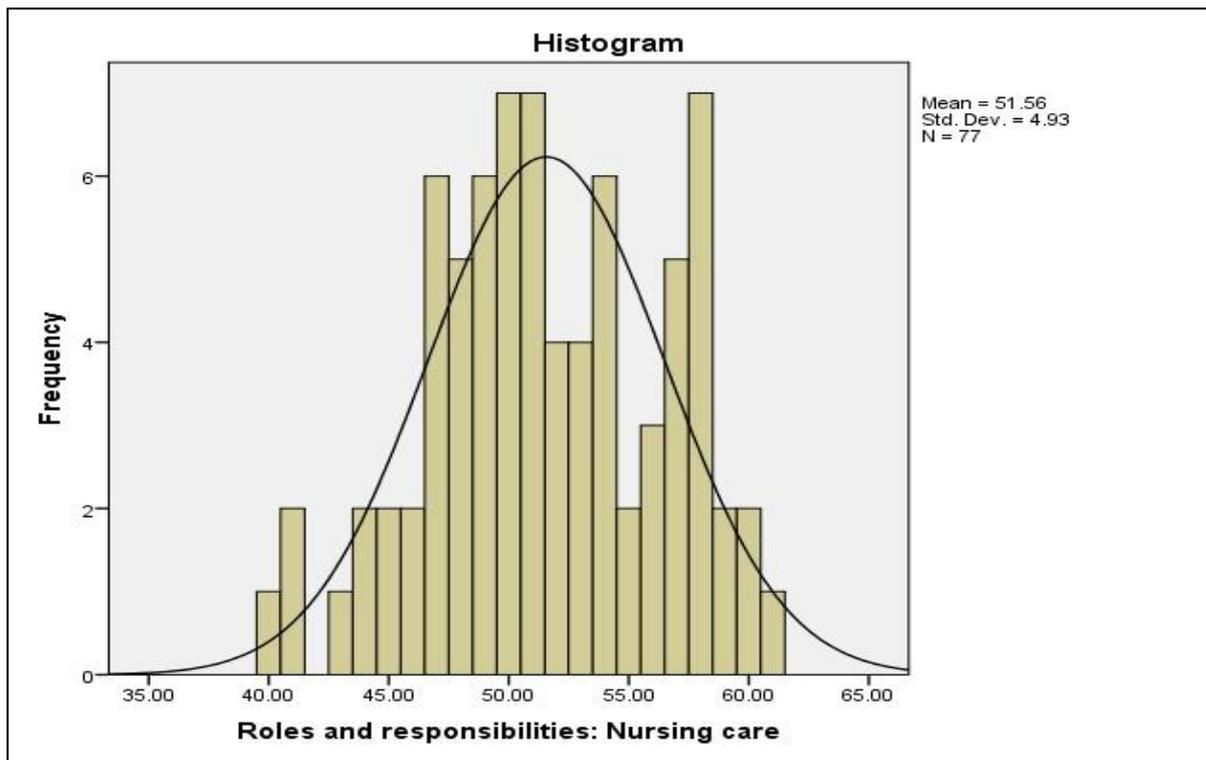
Similarly, approximately equivalent proportions of the respondents disagreed (29.9%; n=23) and strongly disagreed (28.6%; n=22) that they participate in clinical activities without any supervision while a significant proportion (22.1%; n=17) remained neutral. On the contrary, a tenth (10.4%; n=8) strongly agreed and (9.1%; n=7) agreed that they participate in clinical activities without any supervision, with a mean of 2.42.

When respondents were asked about their perception regarding their ability to identify client needs, (44.2%; n=34) of respondents strongly agreed and a further (35.1%; n=27) agreed that they were able to identify client needs accurately, whereas (15.6%; n=12) remained neutral. In comparison, a minority of respondents disagreed (3.9%; n=3) and strongly disagreed (1.3%; n=1) with the statement. The mean score was 4.16.

Surprisingly a majority of respondents (40.3%; n=31) remained neutral, while an even distribution of responses strongly agreed (33.8%; n=26) and agreed (33.8%; n=26) to being held accountable for quality of care provided within the established limits. However, (24.7%; n=19) of respondents disagreed and only (1.3%; n=1) strongly disagreed to the issue, with a mean score of 4.05.

Further, with regard to students given the opportunity to become familiar with the clinical setting policies, procedures and protocols, over a third of the respondents (36.4%; n=28) agreed and virtually a third (29.9%; n=23) also strongly agreed. While (23.4%; n=18) respondents remained neutral, and an equal proportion of respondents (5.2%; n=4) disagreed and strongly disagreed that they were given the opportunity to become familiar with the clinical setting policies, procedures and protocols with a mean score of 3.80.

Responses regarding respondents' ability to collect relevant information from client to identify needs of the client show less than half of the respondents (44.2%; n=34) strongly agreed and (35.1%; n=27) agreed to the statement. Whereas (15.6%; n=12) of respondents had a neutral response, (3.9%; n=3) disagreed and (1.3%; n=1) strongly disagreed, with the mean score of 4.17.



**Figure 4.1: Histogram reflecting sum of roles and responsibilities: Nursing Care**

**4.4.1.1 Participants Overall Score on their Perceptions Regarding Roles and Responsibilities about Nursing Care**

In summary a frequency test was performed on the data. Based on the minimum score of 40 and the maximum of 60; the mean score of the responses in this study was 51.58. Standard deviation was 4.92 and the Skewness was - 0.139. The 25<sup>th</sup> Percentiles score was 48, 50<sup>th</sup> percentile score was 51 and the 75<sup>th</sup> percentile score was 56. Figure 4.1 above indicates the sum of roles and responsibilities about nursing care.

**4.4.2 Roles and Responsibilities in the Clinical Setting: Learning**

Seven items were used to measure the participants’ perceptions regarding their roles and responsibilities in the clinical setting in relation to their learning. The level of agreement and disagreement is illustrated in Table 4.3.

**Table 4. 3: Roles And Responsibilities In The Clinical Setting: Learning**

Variable Specification	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
As a nursing student I am encouraged to engage in life-long learning and professional development through the promotion of nursing excellence	58.4% (n=45)	32.5% (n=25)	6.5% (n=5)	1.3% (n=1)	1.3% (n=1)
Nurses in the clinical setting share their knowledge with students	32.5% (n=25)	32.5% (n=25)	24.7% (n=19)	3.9% (n=3)	6.5% (n=5)
My learning is prioritised over working in the ward	36.4% (n=28)	35.1% (n=27)	22.1% (n=17)	5.2% (n=4)	1.3% (n=1)
I am treated as an extra pair of hands at the expense of my learning	41.6% (n=32)	23.4% (n=18)	20.8% (n=16)	10.4% (n=8)	3.9% (n=3)
I am able to formulate a nursing diagnosis	22.1% (n=17)	41.6% (n=32)	22.1% (n=17)	10.4% (n=8)	3.9% (n=3)
I am able to carry out intervention in line with my learning objectives	31.2% (n=24)	41.6% (n=32)	22.1% (n=17)	2.6% (n=2)	2.6% (n=2)
I am able to evaluate the outcome of the intervention	24.7% (n=19)	48.1% (n=37)	19.5% (n=15)	6.5% (n=5)	1.3% (n=1)

More than half of respondents' (58.4%; n=45) strongly agreed and (32.5%; n=25) of respondents agreed that they are encouraged to engaged in life-long learning and professional development as opposed to (6.5%; n=5) of respondents who remained neutral. However, only (1.3%; n=1) disagreed and another (1.3%; n=1) strongly disagreed with the statement with a mean score of 4.45.

In this study respondents' who strongly agreed (32.5%; n=25) are similar to those respondents that agreed (32.5%; n=25) to the statement that nurses in the clinical setting shared their knowledge with students as opposed to (24.7%; n=19) respondents who remained neutral. On the other hand, a minority of (3.9%; n=3) of respondents disagreed and (6.5%; n=5) strongly disagreed. The mean score was 3.80.

Responding to whether or not respondents' perceived their learning as prioritised over working in the ward, more than a third (36.4%; n=28) of the respondents strongly agreed and (35.1%; n=27) of respondents' agreed that their learning was prioritised over working in the ward while

(22.1%; n=17) of the respondents' remained neutral. On the contrary, (5.2%; n=4) disagreed and only a minority of (1.3%; n=1) strongly disagreed to the statement with a mean score of 4.00.

When asked whether respondents' perceived that they were being used as an extra pair of hands in the ward at the expense of their learning, less than half of the respondents (41.6%; n=32) strongly agreed and (23.4%; n=18) agreed. Of respondent's that remained neutral, a tenth (10.4%; n= 8) of the respondents disagreed with the statement. Although (20.8%; n=16) disagreed and (3.9%; n=3) strongly disagreed with the statement. The mean score was 3.88.

From the results, less than half of the respondents (41.6%; n=32) agreed and only (22.1%; n=17) of respondents strongly agreed that they were able to formulate a nursing diagnosis. However, a significant proportion of (22.1%; n=17) of the respondents were neutral on this point. Furthermore, (10.4% n=8) disagreed and (3.9%; n=3) strongly disagreed that they were able to formulate a nursing diagnosis, with a mean score of 4.14.

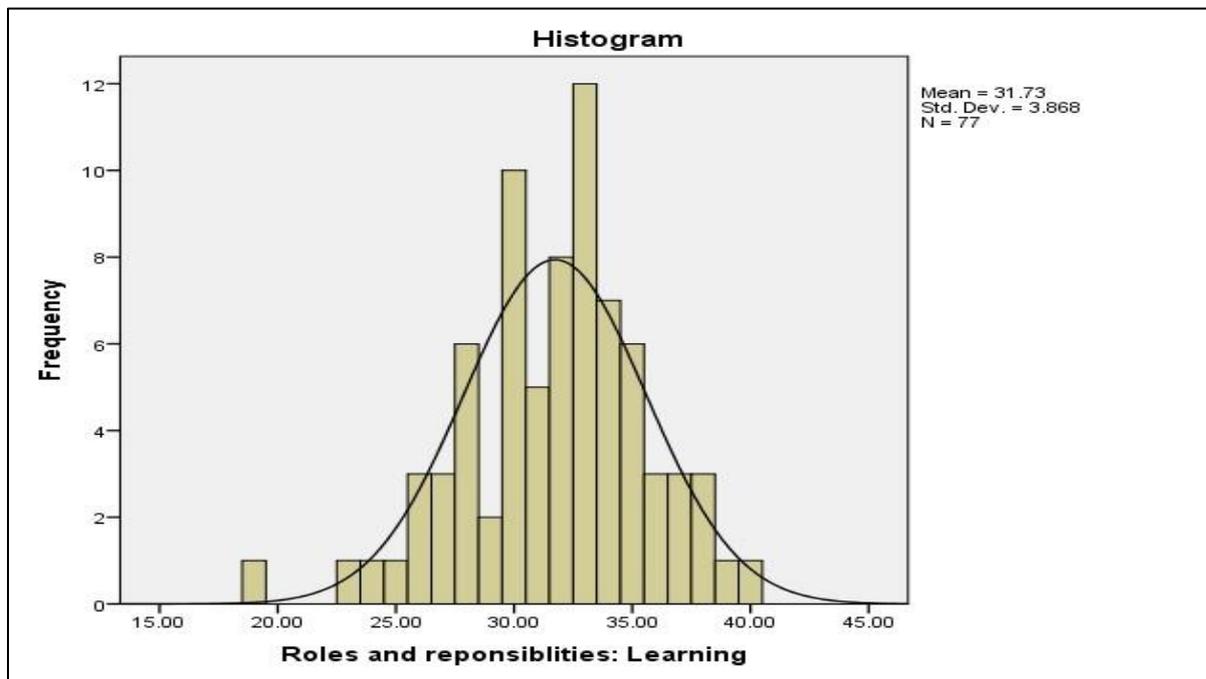
Results of the data analysis further reveal that (41.6%; n=32) agreed and (32.1%; n=24) strongly agreed that they were able to carry out interventions that were in line with their learning objectives. As oppose to (22.1%; n=17) of the respondents that remained neutral about their perception on their ability to carry out interventions that were in line with learning objectives. There was an equal distribution of responses among respondents' that disagreed (2.6%; n=2), and those who strongly disagreed to the statement. The mean score was 3.96.

Similarly, less than half (48.1%; n=37) agreed and (24.7%; n=19) strongly agreed to their perceived ability to evaluate the outcome of their interventions, as opposed to (19.5%; n=15) respondents who reported neutral responses. A minority on the other hand, disagreed (6.5%; n=5) and (1.3%; n=1) respondents strongly disagreed to the statement, with a mean score of 3.88.

#### **4.4.2.1 Participants Overall Score Perception About their Roles and Responsibilities about Learning**

Data analysis using frequency was performed to summarise the sum of the respondents' perception about their role and responsibilities toward their learning. Based on the minimum 19 and the maximum score 40; the 25<sup>th</sup> percentile scored 30, the 50<sup>th</sup> percentile scored 32 and the

75<sup>th</sup> percentile scored 34. The mean score was 31.73, the median score was 32, and the mode was 33. Standard deviation was  $\pm 3.86$  as illustrated in figure 4.2.



**Figure 4. 2: Histogram Illustrating The Sum Of Roles And Responsibilities In The Clinical Setting: Learning**

#### 4.4.3 Respondents Perceptions Regarding Their Challenges in the Clinical Setting

Nine items were used to measure the respondents' perceptions regarding their challenges in the clinical setting. The level of agreement and disagreement are presented in Table 4.4.

**Table 4.4: Information on Perceptions of Students' Regarding Their Challenges in the Clinical Setting**

Variable specification	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
My well-being as a student is respected in the clinical area	28.6% (n=22)	32.5% (n=25)	26% (n=20)	5.2% (n=4)	7.8% (n=6)
As a student I can prioritise my learning	33.8% (n=26)	48.1% (n=37)	15.6% (n=12)	0% (n=0)	2.6% (n=2)
Students are not allowed to prioritise learning over patient safety	11.7% (n=9)	26% (n=20)	29.9% (n=23)	16.9% (n=13)	15.6% (n=12)
When an unplanned learning opportunity is reported in another ward, I'm allowed to leave my allocated task to attend	13% (n=10)	33.8% (n=26)	26% (n=20)	14.3% (n=11)	13% (n=10)
There are limited resources to do nursing care procedures	23.4% (n=18)	32.5% (n=25)	16.9% (n=13)	15.6% (n=12)	11.7% (n=9)
There is a shortage of qualified staff to supervise patient care	27.3% (n=21)	27.3% (n=21)	23.4% (n=18)	14.3% (n=11)	7.8% (n=6)
There is a lack in the student-supervisor relationship	19.5% (n=15)	23.4% (n=18)	27.3% (n=21)	20.8% (n=16)	9.1% (n=7)
Financial constraints made it difficult going to clinical setting	7.8% (n=6)	13% (n=10)	13% (n=10)	24.7% (n=19)	41.6% (32)
Poor staff relationships	24.7% (n=19)	23.4% (n=18)	23.4% (n=18)	16.9% (n=13)	11.7% (n=9)

The results of the study indicate that a little over a third, (32.5%; n=25), of the respondents agreed and of (28.6%; n=22) strongly agreed that their wellbeing as students was respected in the clinical area. While close to a third of the respondents (26%; n=20) remained neutral, the minority (7.8%; n=6) of respondents strongly disagreed and (5.2%; n=4) disagreed that their wellbeing as student was respected in the clinical area. The mean score to the statement was 3.68.

Again, almost half of the respondents' (48.1%; n=37) agreed and (33.8%; n=26) of respondents strongly agreed they were able to prioritise their learning in the clinical area in comparison to (15.6% n=12) of the respondents who remained neutral. A minority of respondents on the contrary (2.6%; n=2) strongly disagreed with the statement. The mean score was 4.10.

Furthermore, while nearly a third of the respondents' (29.9%; n=23) remained neutral about their ability to prioritise learning over patient safety. Furthermore, (26%; n=20) agreed and (11.7%; n=9) of the respondents strongly agreed that they were not allowed to prioritise learning over patient safety as opposed to (16.9%; n=13) of respondents' who disagreed and (15.6%; n=12) of respondents who strongly disagreed that students are not allowed to prioritise learning over patient safety. The mean score for the statement was 3.01.

Though over a third of the respondents (33.8%; n=26) agreed that they were allowed to leave their allocated tasks to attend an unplanned learning opportunity, (26%; n=20) of respondents remained neutral on this as opposed to (14.3%; n=11) of respondents who disagreed and only (13%; n=10) each strongly agreed and strongly disagreed to the statement. The mean score to the statement was 3.19.

Analysis of the respondents' perceptions on the availability of limited of resources to perform nursing care in a clinical setting, reveals that over a third (32.5%; n=25) of respondents agreed and (23.4%; n=18) strongly agreed that there are limited resources to do nursing care. A few respondents (16.9%; n=13) remained neutral, while (15.6%; n=12) disagreed and (11.7%; n=9) respondents strongly disagreed. The mean score to the statement was 3.4.

Equivalent proportions of respondents strongly agree (27.3%; n=21) and agreed (27.3%; n=21), that there is a shortage of qualified staff to supervise patient care. Whereas (23.4%; n=18) of respondents remained neutral on this issue, few (14.3%; n=11) of the respondents disagreed and the minority (7.8%; n=6) strongly disagreed. The mean score was 3.51.

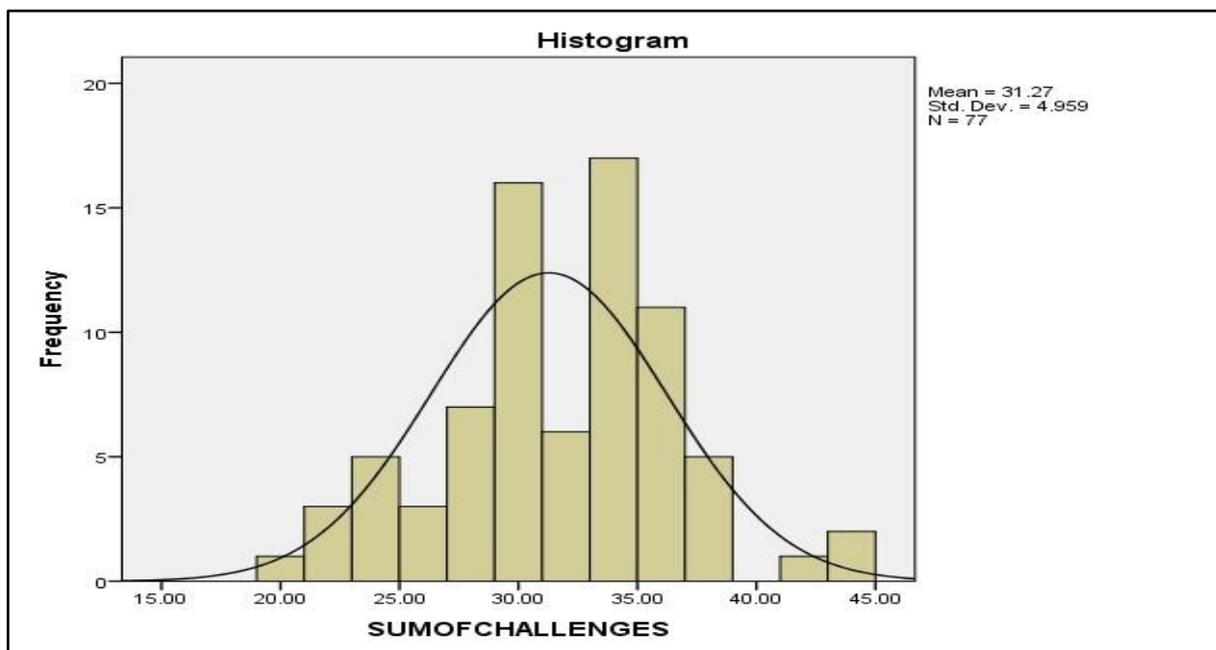
On the issue of whether there was a lack of a positive student-supervisor relationship in the clinical areas or not, the majority (27.3%; n=21) were neutral, contrary to (23.4%; n=18) of the respondents who agreed and (20.8%; n=16) of the respondents who disagreed. In addition, (19.5%; n=15) of the respondents strongly agreed to a lack of student-supervisor relationship as opposed to the minority (9.1%; n=7) of respondents who strongly disagreed. The mean score to the statement was 3.23.

The majority of respondents (41.6%; n=32) strongly disagreed and (24.7%; n=19) disagreed that financial constraints made it difficult for them to go to the clinical setting. While (13%; n=10) of respondents remained neutral on the contrary, (13%; n=10) agreed and only (7.8%; n=6) strongly agreed to the issue. The mean score to the statement was 3.792.

Responding to the issue of staff relationships at the clinical area, where (24.7%; n=19) of respondents strongly agreed, (23.4%; n=18) agreed there was poor staff relationships while (23.4%; n=18) of respondents remained neutral. However, a minority of the respondents (16.9%; n=13) disagreed and (11.7%; n=9) strongly disagreed that there were poor staff relationships. The mean score to the statement was 3.32.

#### 4.4.3.1 Participants Overall Score on Their Perceptions Regarding Challenges in the Clinical Setting

Data analysis using frequency was performed to summarise the sum of the respondents' perceptions regarding their challenges in the clinical setting as illustrated in figure 4.3. Based on the minimum 20 and the maximum score 43; the 25<sup>th</sup> percentile score was 28.5, the 50<sup>th</sup> percentile score was 32, and the 75<sup>th</sup> percentile score was 34.5. The mean score was 31.27, median score was 32, the mode was 33 and the standard deviation was 4.95. This data is captured in figure 4.3 that follows:



**Figure 4. 3: Histogram Reflecting Sum of Challenges Perceived by the Respondents in the Clinical Setting**

#### 4.4.4 Respondents Perception Regarding Support of Students in the Clinical Setting from Facilitators, Mentors, Supervisors, Preceptors and Educators

The respondents' perceptions regarding support of students in the clinical setting were measured using six items. The levels of agreement and disagreement illustrated in Table 4.5.

**Table 4. 5: Level of Agreement and Disagreement Regarding Support of Students in the Clinical Setting from Facilitators, Mentors, Supervisors, Preceptors and Educators**

Variable Specification	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
As a student I am given adequate support by my facilitator in the clinical setting	33.8% (n=26)	41.6% (n=32)	13% (n=10)	5.2% (n=4)	6.5% (n=5)
Facilitators give students immediate feedback after completion of a task	26% (n=20)	48.1% (n=37)	15.6% (n=12)	5.2% (n=4)	5.2% (n=4)
Mentors are competent to teach up to date clinical skills to students	23.4% (n=18)	45.5% (n=35)	19.5% (n=15)	7.8% (n=6)	3.9% (n=3)
Supervisors have an interest in teaching and assessing student performance in the clinical setting	28.6% (n=22)	42.9% (n=33)	11.7% (n=9)	9.1% (n=7)	7.8% (n=6)
I am motivated to learn from my peers in the clinical setting	32.5% (n=25)	46.8% (n=36)	11.7% (n=9)	7.8% (n=6)	1.3% (n=1)
The preceptor promotes learning opportunities for students in the clinical setting	27.3% (n=21)	46.8% (n=36)	15.6% (n=12)	3.9% (n=3)	6.5% (n=5)

The majority of respondents (41.6%; n=32) agreed and a further (33.8%; n=26) of respondents strongly agreed that they were given adequate support by the facilitator in the clinical setting, as opposed to (13%; n=10) of respondents who were neutral. A minority of respondents (5.2%; n=4) disagreed and (6.5%; n=5) strongly disagreed on the issue. The mean score was 3.90.

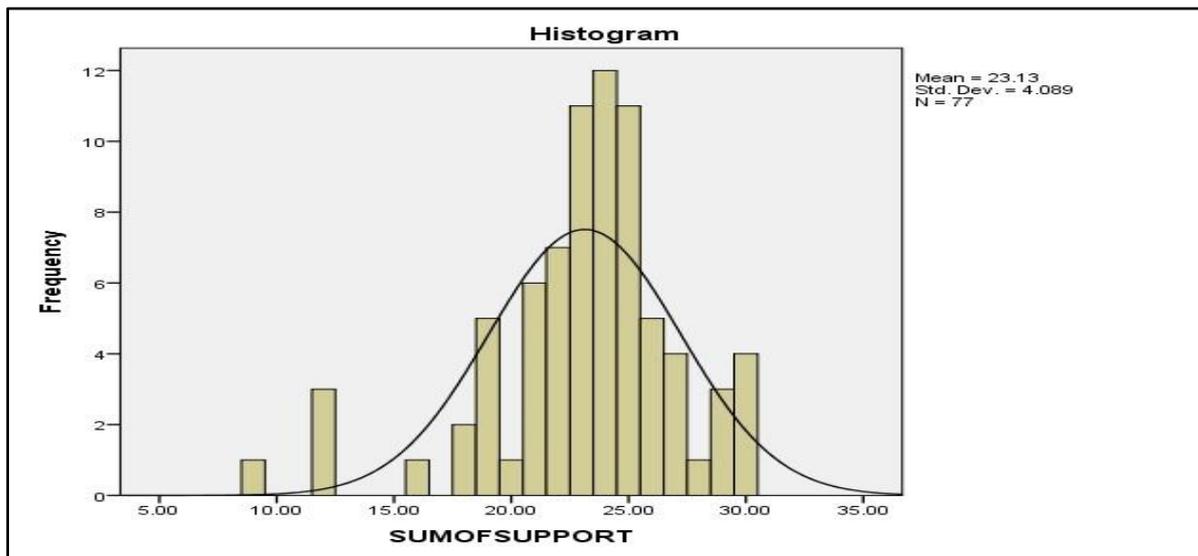
Nearly half of the respondents at (48.1%; n=37) agreed and (26%; n=20) strongly agreed that facilitators give immediate feedback in the clinical area. Whereas (15.6%; n=12) respondents remained neutral on the statement, an equal proportion of respondents (5.2%; n=4) disagreed and strongly disagreed that facilitators gave them immediate feedback after completion of a task. The mean score was of 3.84.

In this study, findings show that (45.5%; n=35) of respondents agreed and (23.4%; n=18) strongly agreed that their mentors were competent to teach up-to-date clinical skills as opposed to (19.5%; n=15) of the respondents who remained neutral. In addition, (7.8%; n=6) of the respondents disagreed and a further minority of (3.9%; n=3) strongly disagreed that their mentors were competent to teach clinical skills that were up-to-date. The mean score was 3.76. Surprisingly, less than half at (42.9%; n=33) agreed and (28.6%; n=22) of the respondents strongly agreed that they perceived the supervisors to have an interest in teaching and assessment of students' performance as opposed to (11.7%; n=9) of respondents who were neutral. On the other hand, (9.1%; n=7) of respondents disagreed and (7.8%; n=6) strongly disagreed that supervisors have an interest in teaching and assessing student performance in the clinical setting. A mean score of 3.75 was recorded.

On respondents' motivation to learn from peers in the clinical areas, less than half (46.8%; n=36) of the respondents agreed and over a third of the respondents (32.5%; n=25) strongly agreed that they were motivated to learn from peers in the clinical setting. Further findings show that while more than a tenth (11.7%; n=9) of respondents remained neutral, a portion of respondents (7.8%; n=6) disagreed and a minority (1.3%; n=1) of respondents strongly disagreed that they were motivated to learn from peers in the clinical setting. The mean score to the statement was 4.01. A majority of respondents (46.8%; n=36) agreed and (27.3%; n=21) strongly agreed that preceptors did promote learning opportunities for students in the clinical setting in contrast to (15.6%; n=12) neutral respondents. Only a few respondents (6.5%; n=5) strongly disagreed and (3.9%; n=3) disagreed on the issue, with a mean score of 3.844.

#### **4.4.4.1 Participants Overall Score on Their Perceptions Regarding Support in the Clinical Setting**

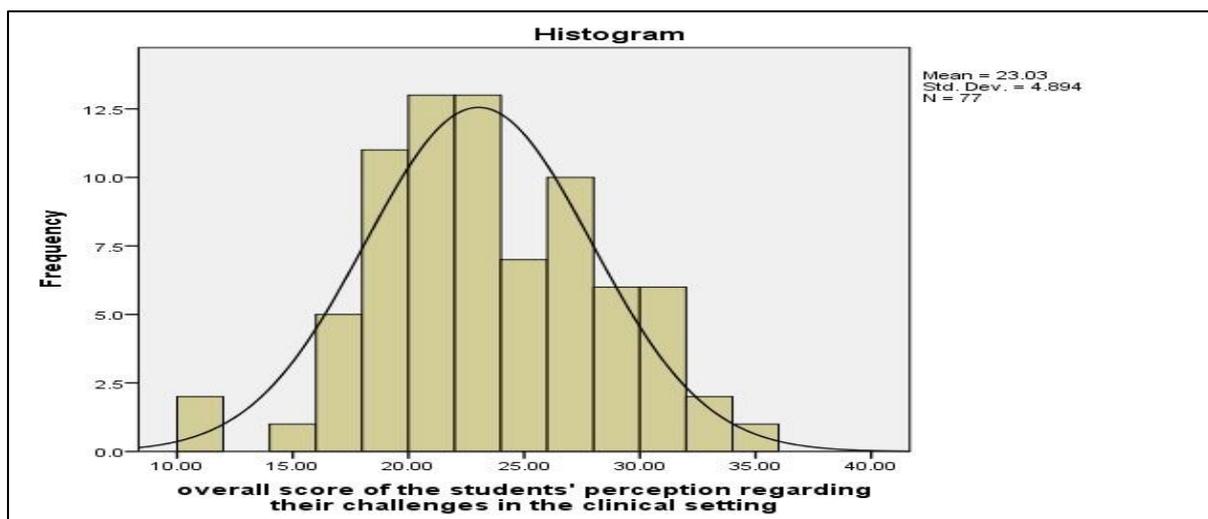
Data analysis using frequency was performed to summarise the sum of the respondents' perceptions regarding their challenges in the clinical setting, illustrated in histogram format figure 4.4. Based on the minimum score of 9 and the maximum score 30: the 25<sup>th</sup> percentile score was 21.5, the 50<sup>th</sup> percentile score was 24, and the 75<sup>th</sup> percentile score was 25. The mean score was 23.12, the median was 24, and the mode was 24. The standard deviation was 4.08 and the standard error of Skewness was .274. See figure 4.4 reflecting the sum of challenges.



**Figure 4. 4 Histogram Reflecting the Sum of Support Perceived by Respondents in the Clinical Setting**

#### 4.4.5 Overall Perceptions of the Respondents Regarding their Challenges in the Clinical Setting

Data analysis using frequency was performed to summarise the overall perceptions of the respondents' regarding their challenges in the clinical setting. Illustrated in histogram format figure 4.5. The mean score was 23.03; Standard Deviation  $\pm 4.894$ . The mode was 21. Based on the minimum 11 and the maximum 34 score: the 25<sup>th</sup> percentile score was 19.5, the 50<sup>th</sup> percentile 23 and the 75<sup>th</sup> percentile 27.



**Figure 4. 5: Histogram Reflecting Respondents Overall Score Regarding their Perceived Challenges in the Clinical Setting**

#### 4.4.6 Association between Respondents' Socio Demographic Variables and their Overall Perceptions regarding student Roles and Responsibilities in the Clinical setting

Chi-squared test was utilised to determine any significant association between respondents' background variables and perceptions regarding their roles and responsibilities. The results however indicated that in this study there was no significant association between the respondents' background variables and their perceptions regarding their roles and responsibilities in the clinical setting. See table 4.6 for details regarding Chi-squared test.

**Table 4. 6: Chi-squared test between respondents' background variables and their perceptions Regarding their Roles and Responsibilities in the Clinical Setting**

Variable	Roles and Responsibilities: Nursing Care		Roles and Responsibilities: Learning		Roles and Responsibilities: Support		Roles and Responsibilities: Challenges		Overall Perceptions Regarding Roles and Responsibilities in the Clinical Setting	
	df	Sig.	df	Sig.	df	Sig.	df	Sig.	df	Sig.
<b>Gender</b>	20	.933	14	.614	15	.326	18	.479	20	.950
<b>Age</b>	40	.119	28	.221	30	.540	36	.716	40	.639
<b>Level of study</b>	20	.286	14	.520	15	.449	18	.664	20	.827
<b>Accommodation</b>	20	.387	14	.495	15	.907	18	.481	20	.854

#### 4.5 Summary of Findings

The main findings of the study in relation to the objectives are summarised as follow and presented in table 4.7.

**Table 4. 7: Participants mean scores on their overall roles and responsibilities and their four sub-domains**

Measure Statistic	Roles and Responsibilities Regarding Nursing Care	Roles and Responsibilities Regarding Learning	Roles and Responsibilities Regarding Challenges	Roles and Responsibilities Regarding Support	Roles and Resp
Mean	51.5	31.7	31.2	23.1	83.3
Median	52	32	32	24	83
Standard deviation	4.92	3.86	4.95	4.08	8.00
Minimum	40	19	20	9	64
Maximum	60	40	43	30	98
Percentiles: 25	48	30	28.5	21.5	78
50	51	32	32	24	83
75	56	34	34.5	25	89.5
Low score	20.7%	27.2%	25.9%	6.49%	15.5%
Moderate score	42.8%	70.1%	55.8%	41.5%	48%
High score	36.3%	1.3%	19.4%	51.94%	36%

Table 4.7 (participants mean score on the overall roles and responsibilities and the four sub-domains) indicates that participants in this study had a moderate mean score of 83.3 and standard deviation  $\pm 8.00$  for their roles and responsibilities. The majority of respondents 84% had a median score of 83 and  $\pm 8.00$  standard deviation (moderate score) and more. Only a minority of 15.5 % had a low score of 75 and below with standard deviation of  $\pm 8.00$ . With a minimum score of 64 and a maximum score of 98, a score of 64-75 is considered low, 76-86 is considered a moderate score and 87-98 is considered a high score. In the 25<sup>th</sup> percentile the score was 78 in the 50<sup>th</sup> percentile the score was 83 and the 75<sup>th</sup> percentile the score was 89.5.

Respondents mean score for the four domains were as follow:

#### **4.5.1 Roles and Responsibilities Regarding Nursing Care**

Respondents had a moderate mean score that was 51.58, median of 52 and standard deviation of  $\pm 4.92$ . About (79.1%) of respondents had a moderate score of 52 with standard deviation of  $\pm 4.92$  or more and only (20.7%) had a low score of 47 and a standard deviation  $\pm 4.92$  for their roles and responsibilities regarding nursing care. Based on minimum and maximum scores of 40 and 60, a score of 40-47 is considered a low score, 48–53 is considered a moderate score and 54–60 is considered high. The 25<sup>th</sup> percentile score was 48, 50<sup>th</sup> percentile score was 51 and in 75<sup>th</sup> percentile the score was 56.

#### **4.5.2 Roles and Responsibilities Regarding Learning**

Respondents had a moderate mean score that was 31.72 and the median 32 with the standard deviation of  $\pm 3.86$ . The majority of respondents (97.3%) had a moderate mean score of 32 and below with standard deviation of  $\pm 3.86$ . A minority of 1.3 percent had a high score. The minimum score was 19 and the maximum score was 40. Based on the minimum and maximum scores, 19–26 is considered a low score, 27-33 is considered a moderate score and 34–40 is considered high score. The 25<sup>th</sup> percentile score 30 and 50<sup>th</sup> percentile score 32 with 75<sup>th</sup> percentile score 34.

#### **4.5.3 Roles and Responsibilities Regarding Challenges**

Respondents had a moderate mean score of 31.27 and the median 32. Standard deviation was  $\pm 4.95$ . The majority of respondents (81.7%) had a moderate mean score of 32 and below with standard deviation  $\pm 4.95$ . A minority of 19.4% of the respondents had a high mean score of 32 and above. Based on the minimum score 20 and maximum score 43, 20–28 is considered a low score, 29–35 is considered a moderate score and 36–40 is considered a high score. The 25<sup>th</sup> percentile score was 28.5, the 50<sup>th</sup> percentile was 32 and 75<sup>th</sup> percentile was 34.5.

#### **4.5.4 Roles and Responsibilities Regarding Support**

The respondents had a high mean score of 23.12, and the median 24. Standard deviation was  $\pm 4.08$ . About (93.4%) of respondents had a high mean score and below. While only a minority of 6.4 % of respondents had a low mean score regarding the support with their roles and responsibilities. Based on the minimum score of 9 and maximum score of 30, 9 – 16 is considered a low score, 17 – 23 is considered a moderate score and 24 – 30 is considered a high

score. The 25<sup>th</sup> percentile range score was 21.5 and 50<sup>th</sup> percentile was 24 while the 75<sup>th</sup> percentile score was 25.

Pearson's Chi-squared test showed no significant association between participants' sociodemographic variables and their overall perceptions regarding their roles and responsibilities in the clinical setting in any of the four domains.

#### **4.6 Conclusion**

This chapter an analysis of the information derived from the questionnaires with the selected participants were done. Questionnaire scores were presented and statistically analysed. In the final chapter that follow, discussion, conclusion and recommendations will guide this study.

## **CHAPTER 5**

### **DISCUSSION, CONCLUSION AND RECOMMENDATIONS**

#### **5.1 Introduction**

This chapter presents a discussion of the findings, limitations, recommendations and conclusion of this research. The purpose of the study was to explore the undergraduate nursing students' perceptions regarding their roles and responsibilities in one of the Higher Education Institution in KwaZulu-Natal. Furthermore, the research aimed to meet the following objectives: a) to explore student's perception of their role and responsibilities in the clinical setting; b) to explore perceived challenges by students in the clinical setting; and c) to explore support for students in the clinical setting. The findings are discussed in relation to the research objectives and literature of previous studies on this topic of research.

The response rate was approximately 77% and a response rate of above 60% is considered acceptable according to Johnson and Wislar (2012). In this study, the availability and response rate from the first-year respondents were significantly less in comparison to second year level.

The following findings are discussed: socio demographic variables, the students' perceptions regarding their roles and responsibilities in the clinical setting in a sub-division of nursing care and students learning (main considerations), the students' perceptions regarding their challenges (main considerations) and the students' perceptions regarding support of students in the clinical setting (main considerations).

#### **5.2 Discussion**

In this section, the finding of this study will be discussed, based on the respondents' sociodemographic variable characteristics and their perceptions regarding their roles and responsibilities in the clinical settings. The findings here will be compared with early evidence on the topic to draw any similarities and differences, and to provide possible explanations for such observations.

## **5.2.1 Participants Socio-Demographic Characteristics and their Perceived Roles and Responsibilities**

Four socio-demographic variables of respondents were included in this study as considered relevant to the study: gender, age, level of study and accommodation. The findings on these variables are discussed as follows:

### **5.2.1.1 Participants Gender**

Findings of this study show that the majority (88.3%) of participants were females in comparison to (11.7%) male participants. The results are in line with the nursing profession which is dominated by females. The SANC Nursing Stats for Manpower distribution (2016) reveal in the province of KwaZulu-Natal the total amount of registered females (28609) vs. males (2999), Western Cape province the females (15841) vs males (1294) and Eastern Cape province registered females (13975) vs males (1588). Gauteng province is most prominent with the registered females (34024) vs. males (2579) (SANC Nursing Stat Manpower Distribution, 2016). Barrett-Landay (2014) & Hus, Chen & Lou (2010), report nursing historically from the mid-nineteenth century, ostracised males from roles as care takers and nurturers in the profession, Florence Nightingale established nursing as a women's profession. The image of a nurse was portrayed as a, nurturer, humble and selfless and less educated. Females fulfilled these roles and responsibilities that was portrayed.

### **5.2.1.2 Participants Age**

In this study, a total of (22.1%; n=17) participants were 18-24 years old, (20.8%; n=16) of the respondents were 25-30 years old and a majority of participants at 57.1% (n=44) were 31-above see table 4.2 page 49 Thus, findings from this study were that the mean age group of the 77 participants, ranged between 18 – 24 years. From the results in this study, it is concluded that majority of nursing students were adult, mature learners. Drury (2007) assert that potential for role conflict for many students working in the healthcare sector was identified, however, Drury believes that mature students have increased self development, learning and coping skills, and that they possess intrinsic motivation that helps in overcoming challenges in the clinical setting. Drury (2007) assert that research conducted by Holland, potential for role conflict for many students working in the health care sector was identified. Drury (2007) also is of view that mature-aged students identify role conflict as being a significant issue. This conflict arises when there are work and family commitments that both place high demands on the students' time and energy. Transition changes can have significant effects on their lives and the lives of their

families. Nurses in leadership roles act as advocates, accept personal responsibility for their actions and held accountable for judgements, actions and inactions. These values and morals directly relate to self-development and personal maturity.

### **5.2.1.3 Level of Study**

The South African Nursing Council, in terms of section 45(1) of the Nursing Act, 1978 (Act No 50/1978), made regulations to set out schedule for examination admission requirements whereby candidates must complete 40 weeks of the first academic year by the end of the month in which the examination is conducted and achieved at least a 45% continuous assessment in theoretical aspects and 40% in the examination (SANC Regulations: Examination admission requirements, 2017). The majority of participants (76%) were enrolled in their second-year level of study at a Private Nursing College, while the remainder of 23.4% of participants were in the first year level of study. Student enrolment for each year of study was: thirty (n=30) first year, thirty (n=30) second year and forty (n=40) repeat group. Students have to take the responsibility to integrate theory with practice. Baggin and Rugg (2010) suggest that students who are unable to link theory with practice were often left behind or forced to leave nursing. With the evolution of nursing from apprenticeship to a holistic approach, attempt is made by nursing education to bridge the gap between nursing theory and practice. Mabuda (2008) report the problems related to integration of theory into practice as: lack of student involvement during clinical teaching, deficiencies in student evaluation in clinical setting and insufficient accompaniment of students in the clinical setting, Coetzee, 2014, and Mabuda (2008) support this view. In this study, the level of study in relation to participants' ability to integrate theory into practice was a poor score. The failure of first year participants to prioritise learning needs, integration of theory into practice and role conflict can be linked to unclear perception of roles and responsibilities as merely onlookers or providers of care and spending time on routine tasks when entering the clinical setting. As reported by Houghton (2014) students realise in their first placement that reality is not reflected in the clinical setting.

### **5.2.1.4 Accommodation**

The majority at 87% of the participants stayed at home with their parents, while only a little percentage 13% of respondents stayed in the College residences. The majority of students are adult learners and are aged 31 and above, therefore they do not make use of college residence accommodation.

### **5.2.2 Participants' Overall Perceptions Regarding their Roles and Responsibilities in the Clinical Setting**

This study assessed student nurses' perceptions regarding their roles and responsibilities in the clinical setting using a Likert scale self-administered questionnaire. The findings indicate that participants of this study had a moderate mean score of 83.3 (moderate score) and more with standard deviation  $\pm 8.00$  for their roles and responsibilities. The majority of respondents (84%) had a median score of 83 and  $\pm 8.00$  standard deviation. Only a minority of 15.5% had a low score of 75 and below with standard deviation of  $\pm 8.00$ . These findings show that whilst the International Council of Nurses (2010) set fundamental responsibility guidelines for nurses in all spheres to promote health, prevent illness and alleviate suffering, the elements of nursing are not fully internalised and understood as a living document. Thus, the standards of conduct in study and students' work- lives that underpin the framework to achieve clarity regarding codes, roles and responsibilities is not attained. Role clarification can be a crucial issue for effectiveness of care and the probability exists that it can also contribute as a source of conflict (Brault, 2014). Similarly, Smith (2012) reports that confusion exists as students' educational needs are dominant, and takes preference over service needs. However, students need to be reminded that, they are not merely onlookers, but the experience of giving care as part of professional team is vitally helpful to their learning. Again, the findings of the study are in line with studies done by Donaldson and Allan, 2009 and O'Callagan and Slevin (2003). These researchers state that since the inception of Project 2000 challenges have existed such as resentment from students as there was no support nor complete acceptance of their status as an extra pair of hands by the practitioners. However, only a minority of 15.5% did not have a clear perception regarding their roles and responsibilities in the clinical setting. A global perception that for students to gain valuable experience, students must be active participants in the setting to bridge the theory practice gap (Bagglin & Rugg, 2010). Bagglin and Rugg (2010) maintain that the practice placement is the setting to practice and prioritize the varied elements of the modern nursing role.

### **5.2.3 Participants' Scores in the Four Domains**

This study also assessed student nurses' perception regarding their roles and responsibilities in the clinical setting, in four domains: nursing care, student learning, challenges and support. The findings on each domain discussed.

#### **5.2.3.1 Participants' Perception Regarding Roles and Responsibilities: Nursing Care**

Regarding the perceptions of roles and responsibilities toward nursing care, about 79.1% of participants agreed that clarity exists regarding their roles and responsibilities toward nursing care as indicated by their moderate mean score for this domain. Thirteen items were selected for this domain see table 4.3 page 53. However, contradictory results were observed as respondents' perception regarding being an observer in the clinical setting (item 6), although 40.4% agreed to being merely observers, only 19.5% respondents reported their participation in clinical activities without any supervision (item 9). This indicates that students do form part of the workforce and they are not merely observers and a possible result is working independently without supervision. This is not a favourable response, as a significant proportion of participants take part in clinical activities without supervision. The nursing scope of practice ICN (2010) clearly states that students should not undertake any care outside their scope of practice, especially without supervision. The South African Nursing Council stipulates that the student shall function as a member of the health team with certain responsibilities. The National Strategic Plan for Nurse Education Training and Practice (2013) suggest that students' status and support policy award student full student status in nursing programmes (NSP, 2013).

Another contradictory result shows that whilst the majority, at 80.5% of respondents agreed to participating in ward work under the supervision of a registered nurse (item 7), 24.7% of the respondents also agreed to being treated as visitors in the ward (item 8). These results confirm that uncertainty and confusion still exist among students about their outcome objectives, and their progress toward becoming self-directed. Although clinical practice require accompaniment and must be arranged meaningfully to avoid fragmentation, the student remain accountable for their own acts and omissions according to the stage and terminal objectives of the nursing programme (SANC, 2005). Bagglin and Rugg (2010), support the view that in modern nursing, the importance of combining theory and practice in preparation for registration is central to nursing practice. A link exists in the confidence level and competence achieved in the clinical setting. Furthermore, Bagglin and Rugg (2010) suggest that practice placement is the setting to practice and prioritise the various elements of the modern nursing role. Students who are unable able to link theory and practice are left behind. SANC (2005) further states that all nurses have a collective obligation toward the achievement of quality, and safe patient care within a legal and ethical framework (*South African Nursing Act 33, 2005*). Quallington (2012) shares a similar view in that nurses should provide best attainable care for all patients and ethically reflect on their practice to enhance care. The SANC (2005) is of view that nursing

education is directed specifically at the development of the nursing student as an adult on a personal and professional level. In addition, when nursing students show evidence of self-confidence as the outcomes are met, this is portrayed by calm, relaxed and positive attitudes and high self-esteem (Pillay and Mtshali, 2008), students must be reminded that they are not merely onlookers and the experience of giving care as part of the professional team is always vital to learning (Smith, 2012).

### **5.2.3.2 Participants Perceptions Regarding Roles and Responsibilities: Learning**

In relation to participants' perceptions regarding their roles and responsibilities toward learning, the majority, at 97.3% agreed that they have a clear perception toward learning in the clinical setting. On the contrary, results in this study show that about 65% of the participants agreed that they are treated as an extra pair of hands at the expense of their learning (item 4 of domain learning), whilst 72.8% of the participants agreed that they were able to carry out intervention in line with learning objectives (item 6). Thus, the inconsistencies reported by Major (2010) in health care was created by students 'supernumerary status' (extra pair of hands). Health care provision inconsistencies have not yet fully been resolved by removing the supernumerary status. Major (2010) report staff disruptions with student placement. Allan (2009) is of opinion that being an extra pair of hands could be either positive or negative as students' can either be used to get through the work or the fact that students learning might affect the patient care. However, nursing students often feel unattended and left as part of the working force at the expense of their learning needs. The registered nurse has the responsibility to develop, coordinate, present and control nursing education. Appropriate involvement of members of other disciplines in training nurses should not be excluded (SANC, 2005). The guidance provided by the Virginia Board of Nursing (2012) includes the requirement for a student nurse to demonstrate self-direction through actively seeking learning experiences. Preparation for clinical experiences not only assists with a high level of care provided but it closes the theory practice gap in addition. It reasoned that students do not automatically incorporate theoretical knowledge into practice (Coetzee, 2014).

### **5.2.3.3 Participants' Perceptions Regarding Their Challenges**

Findings of the study also show that the majority of respondents at 81.7% had a moderate mean score of 32 and below regarding their perceived challenges in the clinical setting see table 4.5 page 59. However, whilst the majority at 81.9% of respondents can prioritise their learning (item 2 in challenges domain), only 46.8 %of the respondents are allowed to leave their

allocated task to attend an unplanned learning opportunity in another ward (item 4 of domain challenges). Although there is opportunity to learn, it is not prioritised for student learning in the clinical setting. It is reported by Van Graan (2016) that in preparation for the professional nurse's role, undergraduate nursing students are expected to develop and integrate knowledge and practice to achieve an understanding that enable them to make necessary clinical decisions. A study done by Elcock (2006) supports the findings. In his study, students sacrificed learning needs to feel part of a team. It is reported by Elcock (2006), that the students need to feel part of a team is very important to students as acceptance is coupled with access to information and inclusion in discussions.

#### **5.2.3.4 Participants' Perceptions Regarding Their Support**

About 93.4 %of respondents had a high mean score and below toward their perceptions regarding support in the clinical setting. In addition, the majority at 74.1% of the respondents agreed that facilitators give immediate feedback after completion of a task. However, 75.4% of the respondents perceive to have inadequate support from their facilitator in the clinical setting. This means that when facilitators are available in the clinical setting, feedback is only 74.1% of the time. Cunze (2016) reports that vital elements in the support of students in the clinical setting are: role modelling, having a positive attitude and being approachable.

In a study done by Mayall et al. (2008) findings show that 10% of student nurses indicate that in some of their placements they had never been allocated a mentor/facilitator. Emanuel (2013) reported that clinical support is an area identified where improvements achieved, as it is a crucial factor in student support. Due to students working in an evolving healthcare environment, an exceptional standard of nursing care is expected. It is vital that support is continuous, and the provision of constructive feedback and encouragement.

### **5.3 Association between Students' Socio-Demographic Variables and Perceptions Regarding Their Role and Responsibilities**

The Chi-squared test performed in this study showed no significant association between background variables and students' perceptions of their roles and responsibilities in the clinical settings. This could be attributed to the homogeneous nature of the respondents in relation to their background variables. Although age is a common variable in most research, each study shows a different relationship with regard to professional roles and responsibilities. The University of Glasgow (2006) is of view that historically the intimate body service related to nursing care was inappropriate for young unmarried or well- bred females. To clean and feed

another person was a domestic task that servants did. Over time, demand grew for better nursing care level, skills and confidence in the clinical setting. Thus, as confidence is a component of a professional, self-confidence comes with age and more confidence with the educational process. Drexler (2010) report that final year students lack in confidence and experience apprehension in fulfilling expectations regarding responsibilities of a professional nurse. In contrast, younger students who were more conforming show less self-confidence in their knowledge and are willing to go along with superiors regardless of their own knowledge. In contrast, Lacoubucci, Daly and Griffin (2012) report that results from an exploratory study regarding professional values and self-esteem and ethical confidence among nurse students show that the mean age of participants were 21 years. The senior nurses in the study internalised high levels of self-esteem and professional nursing value.

Furthermore, Franklin (2013) and McLaughlin, Muldoon and Moutray (2010) regarding gender, it is historically dominated by females as the nursing role has been based on female traits such as being a nurturer, compassionate, empathetic and sympathetic. In addition, McLaughlin et al (2010) state that the female dominated nature of nursing gender bias and stereotypes that is inherent in nursing education makes it uncomfortable not only for males but also for those individuals with a less gender type view. Studies by Franklin (2013) support this view. Fatum (1993) reports that, due to females mainly following traditional roles, student accommodation for females is mainly in their family homes.

#### **5.4 Conclusion of Results**

Students actively promote high levels of moral and ethical principles and accept accountability for their actions however; their ability to maintain client confidentiality is not a 100% as other factors may contribute to violation of client confidentiality.

Taking into consideration the majority response rate of only 40.4% of respondents that have a perception of being merely observers, and not treated as visitors in the ward, the majority of students take part in ward activities without supervision.

While merely a quarter of participants strongly agreed that they are not an extra pair of hands, the participants' ability to identify client needs accurately and respondents' ability to prioritise their learning were low.

Findings in this study show that support in the clinical setting is not sufficient as only a little over a quarter of respondents agreed that support is adequate. The amount of neutral responses

in this study shows that the participants do not have a clear perception of their roles and responsibilities in the clinical setting and they lack self-confidence regarding certain elements portrayed in the statements regarding roles and responsibilities.

The lack of role clarity can be attributed to the respondents' inadequate support in the clinical setting; however, improved facilitation can address the theory-practice gap that possibly exists among respondents.

## **5.5 Limitations of the Study**

Limitations of this study relate mainly to the distribution of the respondents. The variance in study level with 18 participants in the first year of study restricted the analysis and did not allow for significant associations between variables and domains.

A much larger sample is required to carry out a comprehensive analysis. Findings were that some of the socio-demographic data that yielded no significance might in larger sample size show significant associations and interactions.

The second limitation was the use of a self-reported questionnaire only. A mixed method approach to data collection may show that the majority of results voice the participants' perceptions more instead of neutrally scored perceptions.

## **5.6 Recommendations**

Based on the findings of the study the following recommendations are made as a future contribution to improve students' clinical learning regarding their roles and responsibilities.

### **Future research**

The skewness of the data did not permit for more analysis; it is a recommendation that for future studies, a comparative study should be done, focusing especially on how students' gender and level shape their perceptions about their roles and responsibilities in the clinical setting.

A mixed-method follow-up study following a quantitative approach and interview with participants to collect data is recommended to gain an in-depth understanding of nursing students perceptions of their roles and responsibilities as well as the challenges they face in the clinical setting in the South African context.

### **Education**

Facilitation in the clinical setting should be addressed, especially in the curriculum to assist undergraduate nursing students understand their clinical roles and empower them to self-direct their clinical placement experiences with clinical competencies and address challenges experienced regarding practical learning objectives.

### **Healthcare policy-holders**

Addressing clarification of students' roles and responsibilities in the clinical setting through inter-professional collaboration, especially between nursing practice and educational institutions to ensure that no inconsistencies in care exist.

### **Nursing practice**

Clarifying students' roles and responsibilities through education and role modelling will increase confidence and level of care. There is also the need to build in an effective and efficient feedback system in order to monitor progress and address emerging challenges promptly.

Manage student expectations before entry and during the course so clarity can exist and an understanding of their roles and responsibilities is evident.

Facilitate communication such as dialogue between staff and students as an activity central to the course whereby all students are required to participate.

### **5.7 Conclusion**

This chapter outlined the discussion, conclusion of results and recommendations of this study.



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## LIST OF ANNEXURES

### Annexure 1: Research instrument

#### Questionnaire:

Dear Respondent

You are requested to participate in a research study. By completing the questionnaire, you voluntarily agree to participate in this research study. Data collected for the purpose of the research will remain confidential and anonymous. You may choose to withdraw from the study at any given moment. The results of the study may be published.

The title of the study is: Exploring Students' Perceptions Regarding their Role and Responsibilities in the Clinical Setting at a Selected Nursing Education Institute (NEI) in KwaZulu-Natal.

#### Part 1: Demographic Data

1. Gender:  Female  
 Male
  
2. Age:  18 – 24  
 25 – 30  
 31- Above
  
3. What is your level of study:  
 1<sup>st</sup> year  
 2<sup>nd</sup> year
  
4. Where do you stay:  College Residence  
 Home with parents

Read the statement and rank your perception of student rights in the clinical setting by ticking the response of your choice:

1=Strongly agree (SA), 2=Agree (A) 3=Neutral (N), 4=Strongly disagree (SD),5=Disagree (D).

Section B: Part 2

Students perceptions of their roles and responsibilities in clinical setting

Statement regarding student roles and responsibilities in the clinical setting:	Strongly Agree 5	Agree 4	Neutral 3	Strongly Disagree 2	Disagree 1
5. I maintain client confidentiality in the clinical setting					
6. As nursing student I actively promote the highest level of moral and ethical principles and accept responsibility for my actions					
7. As nursing student I am encouraged to lifelong learning and professional development through the promotion of nursing excellence					
8. As nursing student I can take appropriate action to ensure safety of clients, self and others					
9. Nurses in the clinical setting share their knowledge with students					
10. As student I communicate truthful, timely and accurate					
11. I am part of the ward staff compliment					
12. I am merely an observer in the clinical setting					
13. My learning is prioritised over working in the ward					
14. I participate in ward work under supervision of a registered nurse					
15. I am treated as a visitor in the ward					
16. I participate in clinical activities without any supervision					

17. I am treated as extra pair of hands at the expense of my learning					
18. I am able to identify clients' needs accurately					
Statement regarding student roles and responsibilities in the clinical setting:	Strongly Agree 5	Agree 4	Neutral 3	Strongly Disagree 2	Disagree 1
19. I am held accountable for the quality of care provided within the established objectives					
20. Students are given the opportunity to become familiar with the clinical setting policies, procedures and protocols					
21. I am able to collect relevant information from the client to identify clients' needs					
22. I am able to formulate nursing diagnosis					
23. I am able formulate smart objectives according to patients' needs					
24. I am able to carry out intervention in line with my learning objectives					
25. I am able to evaluate the outcome of the intervention					

Part 3: Information on perceptions of students regarding their challenges in the clinical setting.

Statement regarding student challenges in the clinical setting:	Strongly Agree 5	Agree 4	Neutral 3	Strongly Disagree 2	Disagree 1
26. My well-being as a student is respected in the clinical area					
27. As a student I can prioritise my learning					
28. Students are not allowed to prioritise learning over patient safety					
29. When an unplanned learning opportunity is reported in another ward, I'm allowed to leave my allocated task to attend					

30. There are limited resources to do nursing care procedures					
31. Shortage of qualified staff to supervise patient care					
32. Lack in student-supervisor relationship					
33. Financial constraints made it difficult going to clinical setting					
34. Poor staff relationships					

Part 4: Information with regards support of students in the clinical setting from facilitators, mentors, supervisors, preceptors and educators:

Statements regarding support of students in the clinical setting from facilitators, mentors, supervisors, preceptors, educators	Strongly Agree 5	Agree 4	Neutral 3	Strongly Disagree 2	Disagree 1
35. As student I am given adequate support by my facilitator in the clinical setting					
36. Facilitator give students immediate feedback after completion of a task					
37. Mentors are competent to teach up to date clinical skills to students					
38. Supervisors have interest in teaching and assessing student performance in the clinical setting					
39. I am motivated to learn from my peers in the clinical setting					
40. Preceptor promotes learning opportunities for students in the clinical setting					

Thank you for your participation.

Annexure 2: **Information leaflet**

**INFORMATION GIVEN TO PARTICIPANTS INFORMATION DOCUMENT** Study title: **EXPLORATION NURSING STUDENTS PERCEPTIONS REGARDING THEIR ROLES AND RESPONSIBILITIES IN THE CLINICAL SETTING AT A SELECTED NURSING EDUCATION INSTITUTE (NEI) IN KWAZULU-NATAL**

Dear Nursing Students

**INTRODUCTION**

I, Mrs. J Maritz, am a student at University of KwaZulu-Natal doing Masters degree in Nursing Education. As part of my studies at the University I am required to conduct a study in an area of my interest. My study is **exploration of nursing students' perception regarding their roles and responsibilities in the clinical setting at a selected nursing education institute (NEI) in Kwazulu-Natal.**

I am requesting your participation in this study because you meet the criteria of the people who are eligible to participate in the study. The purpose of the study is to explore nursing students' perceptions regarding their roles and responsibilities in the clinical setting at a selected nursing education institute (NEI) in Kwazulu-Natal. This is to clarify roles and responsibilities of student nurses in the clinical setting, challenges and support of nursing students are faced with when they are in the clinical setting. The study findings may help to. The findings of the study may assist in increased output of competent nursing professionals when nursing students complete their studies. Higher Education Institutions may find the feedback from students valuable and can lead to changes in clinical experiences for nursing students with regards to their roles and responsibilities. Please note that there are no incentives for the participation.

If you agree to participate, you will be provided with a structured questionnaire and requested to complete it upon your voluntary agreement to participate in the study. The researcher will liaise with your academic director to complete the questionnaire during lunch time. Completing the questionnaire will take 30minutes of your lunch time. Your information you give will be treated utmost confidentiality. Any personal information will not be disclosed unless required by law. Your names will not appear anywhere in the questionnaire or the study findings. You are requested not to put your names on the questionnaires provided. There are no expenses involved because the study will be conducted during usual school days at lunch time.

Please feel free to ask questions you may have so that you are clear about what is expected of you. You are free to participate or not to participate in this study. You are free to withdraw from the study at any stage without repercussions. There will no risks attached to your participation. The results of the study will be made available to you on completion of this study.

Please feel free to ask any questions you may have so that you are clear about what is expected of you.

Thank you for your time and cooperation

Yours sincerely

Signature.....

Mrs. J Maritz

Date: .....

Contact details of the researcher for further information/reporting of study related  
Matters

Mrs. J Maritz

Contact number: 0745850787

Email: [juljoubert@yahoo.com](mailto:juljoubert@yahoo.com)

**Supervisor contact details:**

[Ms. M. Dube]

Howard College Campus

School of Nursing and Public Health

4<sup>th</sup> Floor Desmond Clarence Building

4041 Durban. South Africa

Email: [dubeb@ukzn.ac.za]

HSSREC Research Office: Mariette Snyman

Contact number: 031- 2608350

Email: [snymanm@ukzn.ac.za](mailto:snymanm@ukzn.ac.za)

### **Annexure 3: Informed consent form**

#### **Consent to participate in research**

Dear Nursing Students

I, Mrs. J Maritz, a student at the University of Kwazulu-Natal, as one of the requirements to complete my studies, I am conducting a study through the college of Health Sciences, School of Nursing and Public Health, University of Kwazulu-Natal.

The title of the study is: *Exploration nursing students' perception regarding their roles and responsibilities in the clinical setting at a Selected Nursing Education Institute (NEI) in Kwazulu-Natal*. You have been asked to participate in a research study on: exploration of nursing students' perceptions regarding their roles and responsibilities in the clinical setting. The purpose of the study is to explore nursing students' perception of their roles and responsibilities in the clinical setting.

You have been informed about the study by: Mrs. J Maritz- contact number 0745850787, Email: [juljoubert@yahoo.com](mailto:juljoubert@yahoo.com). You may contact me at any time if you have any question about the research.

You may contact the researcher's supervisor- [Ms. M. Dube]- contact number +27312602497, Email: [dubeb@ukzn.ac.za](mailto:dubeb@ukzn.ac.za)

You may contact HSSREC Research office- Mariette Snyman contact number 031- 2608350, Email: [snymanm@ukzn.ac.za](mailto:snymanm@ukzn.ac.za)

Your participation in this research is voluntary and you will not be penalised if you refuse to participate or decide to stop at any time.

If you agree to participate, you will be given a signed copy of this document and the participant information sheet, which is written summary of the research.

The research study including the above information has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate. I have been given opportunity to ask questions that I might have for my participation in the study.

Signature of participant.....

Date.....

### **Annexure 4: Application for permission to conduct research**

## **APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH PROJECT**

Juliette Maritz  
Student number:215079589  
University of KwaZulu-Natal  
School of Nursing and Public  
Health/ Howard College Campus  
Cell: 0745850787  
**E-mail: juljoubert@yahoo.com**  
18/8/2016

**To:** Dean and Head of School  
DT Private Nursing Institute  
P.O Box 18420  
Dalbridge  
4014  
Durban, South Africa  
Tel: 031 202 7189

Dear Mrs Mofokeng

### **RE: Requesting permission to conduct a research project**

I am a student at the University of KwaZulu-Natal, School of Nursing and Public Health doing a Master's degree in Nursing Education. I hereby request permission to conduct a research project in the institution. The title of proposed study is: *Exploring the Students' Perceptions Regarding their Role and Responsibilities in the Clinical Setting at a Selected Nursing Education Institute (NEI) in Kwazulu-Natal.*

Madam, in order to complete a course work Master's degree, I am required to do a research thesis. The reason that I am approaching you is to request permission to conduct my research project in the Private Nursing Institute. The data will be collected after getting Ethical clearance from University of KwaZulu-Natal, Research Ethics Committee.

Hoping for your favorable response to my request, I thank you in advance.

Yours sincerely  
Juliette Maritz  
0745850787  
Supervisor: Ms. M. Dube  
4th Floor, School of Nursing and public Health, UKZN  
Contact number: 031 260 2497  
Email: [dubeb@ukzn.ac.za](mailto:dubeb@ukzn.ac.za)

## **Annexure 5: Letter granting permission to conduct study**



Department of Education Registration No. 2009/FE07/017  
PTY LTD Reg No. 2005/042193/07  
SANC No. S1675  
286 UMBILO ROAD DURBAN  
P.O. Box 18420 DALBRIDGE 4014  
Tel no. 031-2022030 Fax no. 031-2022031  
Email address: [dtnursinginstitute@telkomsa.net](mailto:dtnursinginstitute@telkomsa.net)  
19 August 2016

University of Kwazulu-Natal  
School of Nursing and Public Health  
Howard College Campus

### **PERMISSION TO CONDUCT A RESEARCH PROJECT**

DT Nursing Institute is gladly permitting you to do a research project on “Exploring The Perception of Student Nurses Roles and Responsibilities in the Clinical setting at a selected Higher Education Institution in KwaZulu Natal”.

The research can be commenced after getting ethical clearance from the University of KwaZulu Natal from the research ethics committee.

Should you require further information, kindly contact Mrs MD Mofokeng the principal on 031 202 7189.

Thank You,  
MRS M.D. Mofokeng(Principal)

## Annexure 6: Ethical clearance



8 September 2016

Mrs Juliette Maritz 215079589  
School of Nursing & Public Health  
Howard College Campus

Dear Mrs Maritz

Protocol reference number: HSS/1385/016M

Project Title: Exploring student nurses perception regarding their roles and responsibilities in the clinical setting at one of the higher education Institutions in KwaZulu-Natal

### Full Approval – Expedited Application

In response to your application received 19 August 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

**PLEASE NOTE:** Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shamila Naidoo (Deputy Chair)  
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Mrs M Dube  
Cc Academic Leader Research: Professor M Mars  
Cc School Administrator: Ms Caroline Dhanraj

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Humanities & Social Sciences Research Ethics Committee

Dr Shanika Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag 254001, Durban 4001

Telephone: (27) 031 260 3587/933004557 Facsimile: +27 (0)31 263 4609 Email: [dmhapp@ukzn.ac.za](mailto:dmhapp@ukzn.ac.za) / [ethics@ukzn.ac.za](mailto:ethics@ukzn.ac.za) / [ethics@ukzn.ac.za](mailto:ethics@ukzn.ac.za)  
Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)

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Faculty Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

## Annexure 7: Editor certificate

Asoka ENGLISH language editing CC

CC 2011/065055/23

Cell no.: 0836507817



### DECLARATION OF ENGLISH LANGUAGE EDITING

This is to certify that I have English Language edited 112 pages of the dissertation

*Exploring Students' Perceptions Regarding their Roles and Responsibilities in the Clinical Setting At A Selected Nursing Education Institute (NEI) in Kwazulu-Natal.*

**Candidate: Maritz J**

SATI member number:

1001872

### DISCLAIMER

Whilst the English language editor has used electronic track changes to facilitate corrections and has inserted comments and queries in a right-hand column, the responsibility for effecting changes in the final, submitted document, remains the responsibility of the author in consultation with the supervisor.

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Director: Prof. Dennis Schaffer, M.A.(Leeds), PhD, KwaZulu (Natal), TEFL(London), TITC Business English, Emeritus Professor UKZN. Univ. Cambridge Accreditation: IGCSE Drama. Research Fellow, Durban University of Technology.