THE VIEWS OF DIFFERENT CATEGORIES OF NURSES ON CLINICAL SUPERVISION IN THE SOUTH AFRICAN MILITARY HEALTH SERVICES (SAMHS)

by

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DECLARATION BY THE CANDIDATE

I, Aléshia Coetzee, declare that the dissertation on A DESCRIPTION OF THE VIEWS OF DIFFERENT CATEGORIES OF NURSES ON CLINICAL SUPERVISION IN THE SOUTH AFRICAN MILITARY HEALTH SERVICE herby submitted by me for the masters degree at the University of the Free State is my own independent work and has not previously been submitted by me at another university/faculty. I furthermore cede copyright of the dissertation in favour of the University of the Free State.

_____ 31 January 2013

SIGNATURE **DATE**

(Mrs Aléshia Coetzee)
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This dissertation is dedicated to my son for his patience, love and support

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SUMMARY

In the South African Military Health Service (SAMHS) clinical supervision is the responsibility of both the nurse educator and the professional nurse. However, the insufficiency of clinical departments in the military service triggered the researcher's interest in how clinical supervision is experienced by the different nursing categories.

The objectives of the study were to determine the views of nurse educators, professional nurses, nursing students and pupil enrolled nurses with regard to clinical supervision in the SAMHS and to formulate recommendations for improving clinical supervision based on the results.

The following research question was evaluated: How do the different categories of nurses view clinical supervision in the South African Military Health Services?

The research methodology constituted a non-experimental descriptive exploratory design with a quantitative approach. Self-administered questionnaires were used for data collection. The population comprised of nurse educators, professional nurses, nursing students and pupil enrolled nurses employed in the SAMHS. A random sampling technique was used and all students available at the time of data collection were included in the study. The final sample of nursing students and pupil enrolled nurses was n=148 (56%:264) of a total population of 264 students and the sample size of nurse educators and professional nurses was n=136 (20%:691).

Prior to commencement of the research, approval for conducting the study was obtained from the Ethics Committee of the Faculty of Health Sciences at the University of the Free State (UFS), the Military Health Ethics Committee, the Chief Executive Officers of the various military hospitals, the Commanding Officer of the SAMHS nursing colleges, the Officers in Charge of each nursing college as well as the respondents who participated in the study. Data for the

study was collected in a four-week period, the first of which took place at 3 Military Hospital. The second week saw data collection at 2 Military Hospital and the nursing college in Cape Town. The last two weeks were spent at 1 Military Hospital and the nursing college in Thaba Tshwane.

The ethical principles stated in the proposal were strictly adhered to as the research involved human respondents. The respondents were asked to complete questionnaires voluntarily and they were assured that their participation and the information they provided would not be used against them. They were also assured of their right to confidentiality and anonymity. Anonymity was preserved by not revealing any of the names of the respondents who took part in the research study. Confidentiality was ensured by denying unauthorised access to data. Respondents were informed of their right to withdraw from the study at any stage.

Each complete questionnaire was coded, before a biostatistician of the UFS's Department of Biostatistics assisted with the data analysis. Descriptive statistics measures such as frequency and percentage distributions were obtained.

A conceptual framework of three dimensions, namely the clinical supervision prerequisites, the core of clinical supervision and the outcomes of clinical supervision were used to guide the discussion in Chapter 2 on clinical supervision.

Certain recommendations were made. Some of these included that clinical supervision should be given priority and that the appointment of clinical mentors and preceptors and the establishment of clinical departments in the SAMHS should be investigated. Nurse educators and professional nurses should be jointly responsible for clinical teaching and support of students in the clinical learning environment. Furthermore, it is recommended that nurse educators should provide professional nurses with a structured clinical supervision

programme and that formal written contracts between nurse educators and students be drawn up. The supernumerary status of students needs to be maintained, and, lastly, the nurse-educator student ratio needs to be adjusted.

OPSOMMING

In die Suid Afrikaanse Militêre Geneeskundige Diens (SAMGD) is kliniese begeleiding die verantwoordelikheid van beide die verpleegdosent en die professionele verpleegkundige. Tog was dit die afwesigheid van kliniese departemente in the militêre diens tesame met hoe kliniese begeleiding ervaar word, wat die navorser se belangstelling geprikkel het.

Die oogmerke van die studie was om die sienswyses van verpleegdosente, professionele verpleegkundiges, verpleegstudente en leerling ingeskrewe verpleegsters met betrekking tot kliniese begeleiding in die SAMGD te bepaal en om aanbevelings te maak om kliniese begeleiding te verbeter, gebaseer op die uitslae.

Die volgende navorsings vraag is geevalueer: Hoe sien die verskeie verpleeg kategorieë kliniese begeleiding in die Suid Afrikaanse Militêre Geneeskundige Diens?

Die navorsingsmetodologie was ‘n nie-eksperimentele beskrywende verkennende ontwerp met ‘n kwantitatiewe benadering. Daar is gebruik gemaak van gestruktureerde vraelyste tydens data insameling. Die studiebevolking het bestaan uit verpleegdosente, professionele verpleegkundiges, verpleegstudente en leerling ingeskrewe verpleegsters in diens van die SAMGD. ‘n Gerieflike steekproefmetode is gebruik. Alle studente wat beskikbaar was tydens data versameling is in die oorspronlike steekproef ingesluit. Die finale steekproef verpleegstudente en leerling ingeskrewe studente was n=148 (56%:264) van ‘n totale bevolking van 264 en die totale getal verpleegdosente en professionele verpleegkundiges was n=136 (20%:691).

Voor die aanvang van die studie, is goedkeuring vir die uitvoering van die studie van die Etiek Komitee van die Fakulteit Gesondheidswetenskappe van die

Universiteit van die Vrystaat (UV) verkry. Verdere goedkeuring is verkry van die Militêre Gesondheid Etiek Komitee, die Hoof Uitvoerende Offisiere van die verskeie militêre hospitale, die Bevelvoerende Offisier van die verpleeg colleges van die SAMGD, die Offisier in Bevel van elke verpleeg kollege sowel as die respondente wat aan die studie deelgeneem het. Data vir die oorspronklike studie is in vier weke ingesamel, waarvan die eerste week by 3 Militêre Hospitaal plaasgevind het. Insameling van data by 2 Militêre Hospitaal en die verpleeg kollege in Kaapstad het tydens die tweede week plaasgevind. Die laaste twee weke is gespandeer by 1 Militêre Hospitaal en die verpleeg kollege in Thaba Tshwane.

Etiese beginsels wat in die voorstelling vermeld is, is streng nagevolg weens die insluiting van menslike respondente in die navorsing. Die respondente is gevra om vrywilliglik vraelyste te voltooi en hul is verseker dat deelname aan die studie en informasie wat verskaf is nie teen hul gebruik sou word nie. Hul was ook verseker van hul reg tot vertroulikheid en anonimiteit. Anonimiteit is gehandhaaf deur geen name van respondente wat aan die studie deelgeneem het bekend te maak nie. Vertroulikheid was verseker deur te waak teen ongemagtigde toegang tot data. Respondente is in kennis gestel van hul reg om te onttrek van die studie ter enige tyd.

Elke voltooide vraelys was gekodeer, alvorens ‘n biostatikus van die UV se Departement van Biostatistiek gehelp het met data analise deur middel van beskrywende statistiek. Maatstawwe soos frekwensies en persentasie distribusies is verkry.

‘n Konseptuale raamwerk van die drie dimensies, naamlik die voorvereistes van kliniese begeleiding, die kern asook die uitkomste van kliniese begeleiding was gebruik om die bespreking van kliniese begeleiding in Hoofstuk 2 te lei.

Die hoof bevinding soos bepaal in die studie was dat kliniese begeleiding deur verpleegdosente en professionele verpleegkundiges in die SAMGD nie gefasiliteer word soos vereis deur die SARV nie. Die mees belangrikste aspek wat verpleegdosente verhoed om kliniese begeleiding te fasiliteer is les aanbiedings, terwyl ‘n tekort aan personeel en ‘n hoë werkslading professionele verpleegkundiges se pogings om student in die leeromgewing te ondersteun, bemoeilik.

Aanbevelings wat gemaak is was, byvoorbeeld, dat kliniese begeleiding geprioritiseer word, dat die aanstelling van kliniese mentors en leermeesters sowel as die totstandkoming van kliniese departemente in die militêre geneeskundige diens ondersoek word. Verpleegdosente en professionele verpleegkundiges moet gesamentlik verantwoordelikheid wees vir kliniese onderrig en ondersteuning van studente in die kliniese leeromgewing. Verder word daar aanbeveel dat verpleegdosente ‘n gestruktureerde kliniese begeleidings program aan professionele verpleegkundiges beskikbaar moet stel en dat formele geskrewe kontrakte tussen verpleegdosente en student opgetrek moet word. Die botallige status van studente moet gehandhaaf word en laastens, moet die verpleegdoent-verpleegstudent ratio aangepas word.

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CHAPTER 1

RESEARCH DESIGN

1.1 INTRODUCTION

Success in nursing education and training cannot be achieved unless an appropriate structured clinical supervision programme for students exist (Mochaki, 2007:32). Students have to be actively involved in the clinical supervision programme (Brammer, 2008:1872; Mackenzie, 2009:239; Mochaki, 2007:32). This teaching and learning approach requires nurse educators and professional nurses to have sound knowledge of the learning needs of students that they are supervising in the clinical setting (Löfmark, Thorkildsen, Räholm and Natvig, 2011:165; Mochaki, 2007:32; Waldock, 2010:14).

Clinical supervision is defined as the establishment of a surrounding (Gopee, 2008:81; Mochaki, 2007:34) which allow students to both reflect and develop themselves on personal, professional and educational level through clinical experiences while still rendering high quality patient care (Dempsey, Cuthel and McMenamin, 2012:7; Kilminster, Cottrell, Grant and Jolly, 2007:3; Mackenzie, 2009:240; Walker, 2009:12).

A structured clinical supervision programme entails the development of students in the clinical setting that empowers them to render physical, psychological, spiritual and social support to patients (Mochaki, 2007:34). An insufficient support system in the clinical setting demoralize students to observe for learning opportunities (Brammer, 2008:1870; Mabuda, Potgieter and Alberts, 2008:20) and the outcome leads to deprivation of the expansion of practical and theoretical knowledge, where as a clinical setting with restricted exposure but loaded with support, offer students the change to analyse the latest physical conditions and teach them methods to attend to it (Mabuda et al., 2008:20).

1.2 PROBLEM STATEMENT

From the viewpoint of the researcher it seems as if clinical supervision rendered by nurse educators and professional nurses, as well as the absence of clinical educators in SAMHS, results in unfulfilled student demands in the clinical practice. The researcher believes that the responsibility to ensure that first-, second- and fourth-year nursing students and first- and second-year pupil enrolled nurses receive high quality clinical education and training, to allow them to withstand the challenges they have to face as health care providers, lies with the nursing education and training institutions.

Firstly, nursing education and training institutions need to consider the accumulation of work obligations and insufficient time for completing duties assigned to professional nurses as the most important factors contributing to an unwillingness to supervise students in the clinical setting (Carrigen, 2012:24; Waldock, 2010:15; Walker, 2009:12). It is unfortunate that nurse educators and professional nurses do not allocate time to clinical supervision. Furthermore if they do indeed go to the trouble of doing it, this is possibly the first task delegated to others (Lynch, Hancox, Happell and Parker, 2008:5). Secondly, the view of students as important stakeholders in the clinical environment needs to be investigated and addressed (Lynch, Hancox, Happell and Parker, 2008:5). This could also be true in the SAMHS clinical environment and needs to be reviewed.

The above viewpoint with regard to clinical supervision in SAMHS could be supported with research on students' experiences and their discontentedness with clinical supervision and indicated that neither nurse educators nor professional nurses provided adequate clinical supervision during their clinical placements (Brammer, 2008:1868; Croxon and Maginnis, 2009:237; Mabuda et al., 2008:20). Insufficient clinical supervision may hamper students' professional growth and development, creating clinically incompetent nurse practitioners with

possibly harmful repercussions for the nurse themselves, the nursing profession ant their patients (Brammer, 2008:1869).

Qualitative and quantitative research is conducted nationally and internationally to describe student support in the clinical setting from students' viewpoint (Mabuda et al., 2008:20; Pillay and Mtshali, 2008:47; Waldock, 2010:14). However not much literature exists with regard to the professional nurse's roles in student supervision (Pillay and Mtshali, 2008:47; Waldock, 2010:14).

No study was found that describes the views of the different categories of nurses regarding clinical supervision in the SAMHS. Therefore the researcher is of the opinion that the need exists to address the challenges that nurse educators and professional nurses are facing with regard to clinical supervision of first- and second year pupil enrolled nurses as well as first-, second- and fourth year nursing students in the three military hospitals. Third-year nursing students could not be included in the study due to the fact that there was not a student intake two years before.

This study will therefore seek to answer the following research question:

- How do the different categories of nurses view clinical supervision in the South African Military Health Services (SAMHS)?

1.3 AIM OF THE STUDY

The aim of the proposed study is to describe the views of different categories of nurses on clinical supervision in the SAMHS.

1.4 OBJECTIVES

The objectives of the study are:

- To describe the views of nurse educators, professional nurses, nursing students and pupil enrolled nurses with regard to clinical supervision in the SAMHS.
- To formulate recommendations to improve clinical supervision based on the results.

1.5 CONCEPTUAL FRAMEWORK

The conceptual framework of the proposed research study is displayed in Figure 1. A descriptive explanation follows thereafter.

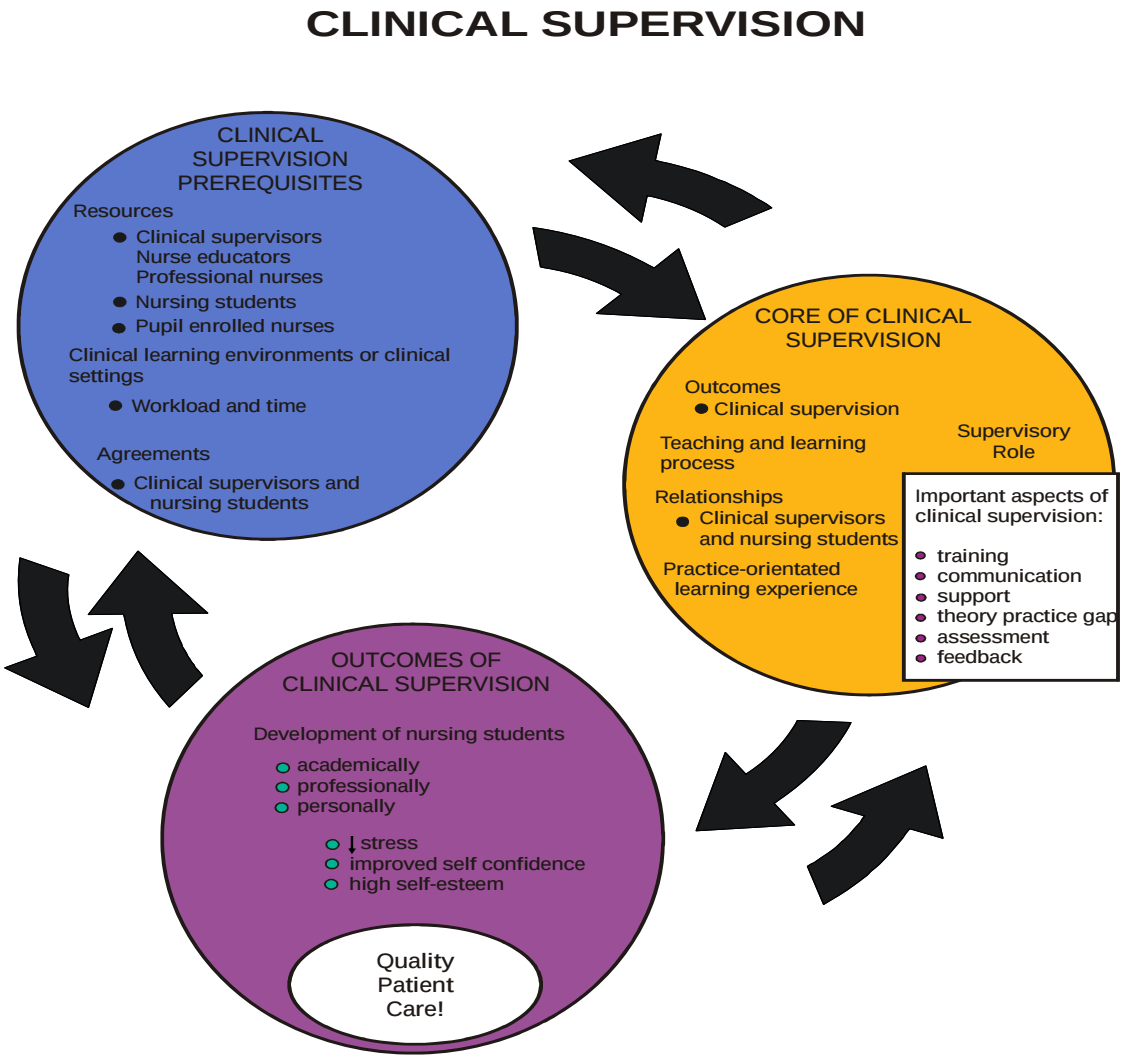

Figure 1: Conceptual framework of clinical supervision (Hyrkås 2000) adjusted (Pillay and Mtshali 2008) adjusted (researcher 2012)

The conceptual framework in Figure 1.1 is adapted from Pillay and Mtshali's (2008:48) conceptual framework which was adjusted from the Hyrkäs model (2000:50) and consists of three essential dimensions for clinical supervision, namely, prerequisites, core and outcomes.

The prerequisites refer to the conditions that need to be established before the clinical supervision process can take place. A shortage of human resources, such as nurse educators and professional nurses, appears to be a major threat for clinical supervision (Mabuda et al., 2008:22; Pillay and Mtshali, 2008:48). Therefore the appointment of skilled clinical supervisors (Bryant, 2010:3; Carrigen, 2012:25) is of utmost importance, not only to see to it that clinical supervision occurs continuously but to ensure that communication exist between the health care institution and the clinical settings (Mabuda et al., 2008:23; Pillay and Mtshali, 2008;48). A clinical supervision agreement, better known as a contract, between the clinical supervisor and the nursing student or pupil enrolled nurse is essential (cf Bryant, 2010:5; Kilminster et al., 2007:10; Pillay and Mtshali, 2008:48). It gives a clear explanation of the clinical arrangements and expectations of clinical supervision such as the duration (Bryant, 2010:5), rules and responsibilities throughout the teaching-learning process (Kilminster et al., 2007:10; Pillay and Mtshali, 2008:48).

The core of clinical supervision requires clearly stated outcomes for all planned clinical supervision sessions. During the clinical supervision sessions the teaching- and learning process that is utilized, needs to promote the accomplishment of the expected clinical supervision outcomes. The process must also include practice-orientated learning experiences. Interaction between the clinical supervisor and the nursing student or pupil enrolled nurse should enhance learning (Kilminster et al., 2007:12; Pillay and Mtshali, 2008:50). Time, placement area, communication, support, bridging the theory-practice gap, assessment and feedback are regarded as important aspects for clinical supervision (Bryant, 2010:4-5; Pillay and Mtshali, 2008:50).

The expected outcomes of clinical supervision are associated with the growth and development (Brammer, 2008:1869) of the nursing student and pupil enrolled nurse on academic, professional and personal level (Bryant, 2010:2; Fowler, Fenton and Riley 2007:2; Pillay and Mtshali, 2008:50).

The nursing student and pupil enrolled nurse benefit from clinical supervision because it definitely decreases stress (Bryant, 2010:3) and anxiety, improves self-confidence (Brammer, 2008:1869; Bryant, 2010:6) and ensures a high self-esteem. In conclusion all three dimensions lead to quality patient care (Pillay and Mtshali, 2008:50).

1.6 CONCEPT CLARIFICATION

1.6.1 Clinical supervision

Clinical supervision refers to the establishment of a surrounding (Gopee, 2008:81; Mochaki, 2007:34) which allow nursing students and pupil enrolled nurses to grow and develop themselves on personal, professional and educational level through clinical experiences while still rendering high quality patient care (Kilminster et al., 2007:3; Mackenzie, 2009:240; Walker, 2009:12). For the purpose of the research study clinical supervision refers to the provision of direct guidance on clinical work and the offering of feedback by nurse educators and professional nurses to first- and second year pupil enrolled nurses as well as first-, second- and fourth year nursing students in the military milieu.

1.6.2 Nursing student

A nursing student is any individual who is registered for a four year nursing course leading to registration as a nurse (general, psychiatric, community and midwifery) according to the South African Nursing Council Regulation R425 of 22 February 1985, as amended. For the proposed research study, a nursing student refers to all first-,

second- and fourth-year students who follow the four-year nursing programme leading to registration as a professional nurse at a SAMHS nursing college.

1.6.3 Pupil enrolled nurse

A pupil enrolled nurse is defined as an individual who undertakes nursing education and training at an approved nursing institution that leads to enrolment as a nurse in the Republic of South Africa according to the South African Nursing Council Regulation R2175 of 1993 as amended. For the purpose of this study a pupil enrolled nurse will be an individual enrolled for a two year course in nursing at a SAMHS nursing college.

1.6.4 Nurse educator

A nurse educator is a qualified registered nurse who lectures and guides students who prepare themselves to enter the nursing profession (Cougar, 2010:Online). For the purpose of the research study a nurse educator refers to a qualified professional nurse who is employed in one of the SAMHS nursing colleges and who has the responsibility to teach theoretical as well as the clinical components of nursing.

1.6.5 Professional nurse

A professional nurse is a person who is qualified and registered with the South African Nursing Council to practice nursing autonomously and who is competent to engage in responsibility and accountability for the practice (South African Nursing Council. *Government Gazette*, 2006:34). For the purpose of the study a professional nurse refers to a health care professional who is directly involved in the basic nursing education and training programme for nursing students and pupil enrolled nurses.

1.6.6 Different categories of nurses

Different categories of nurses refer to nurse educators, professional nurses, nursing students and pupil enrolled nurses.

1.6.7 South African Military Health Services (SAMHS)

SAMHS is the acronym for South African Military Health Services and refers to the medical treatment rendered by military health care personnel to military employees in three military hospitals. Furthermore the South African Military Health Service consists out of three nursing colleges: the main campus Thaba Tshwane situated in Pretoria and two satellite campuses which are located in Bloemfontein and Cape Town respectively. All the campuses comprise of clinical learning areas where students are allocated for clinical practice, according to a scheduled programme. Currently clinical supervision in the clinical practice is performed by nurse educators from the different colleges.

1.7 RESEARCH DESIGN AND METHODOLOGY

The blueprint for the study is described below.

1.7.1 Research design

The research design for the proposed study is quantitative descriptive in nature. The latter research method was selected because it allows a broader study which describes specific details of a situation, has an applied research goal, involves a greater number of subjects and enhances generalization of results (De Vos, Strydom, Fouché and Delport, 2011:96).

1.7.2 Research techniques

For the purpose of data collection two self-administered questionnaires were used. These sought demographic data, included open- and close-ended questions and made use of a 4-point Likert scale that tested respondents' agreement amongst a number of

topics. Existing literature pertaining to the research topic was analysed in order to compile questionnaires in line with the aim and objectives of the study. The measuring instruments include questions related to the following:

QUESTIONNAIRES	
Nurse educators and professional nurses	**Nursing students and pupil enrolled nurses**
Demographic data (6 questions)	Demographic data (6 questions)
Clinical supervision by nurse educators and professional nurses (12 questions)	Clinical supervision of nursing students and pupil enrolled nurses (6 questions)
Roles and responsibilities of nurse educators and professional nurses in the clinical setting (4 questions)	Roles and responsibilities of nurse educators and professional nurses in clinical supervision (4 questions)

The questions included in the questionnaires were coded in accordance with the requirements for computerized statistical analysis.

1.7.3 Population

The population for this study comprised of first- and second-year pupil enrolled nurses (leading to enrolment as a nurse), first-, second- and fourth year nursing students (leading to registration as a professional nurse) as well as the nurse educators and professional nurses employed within the three SAMHS nursing colleges and hospitals, who are directly involved in the basic nursing education and training programmes.

1.7.4 Sampling

A random sampling technique was used to exclude bias (CF. Brink et al., 2008:126; De Vos et al., 2011:226) and to ensure that all nursing educators, professional nurses, nursing students and pupil enrolled nurses were granted the same opportunity during the selection process.

An equal proportion of the respondents from the two campuses were drawn. The researcher obtained name lists for nursing students and pupil enrolled nurses from the human resource department. The names of the nursing students and pupil enrolled were placed into a container. Thereafter the researcher drew the total number of names from the container as shown in table 1.1 and 1.2.

Table 1.1: Sample size of pupil enrolled nurses respective to the different campuses

Name of institution	Population size of pupil enrolled nurses	Sample
Satellite Campus – Bloemfontein	First year = 17	n = 10 (60%)
Satellite Campus – Cape Town	First year = 20	n = 12 (60%)
Satellite Campus – Bloemfontein	Second year = 20	n = 12 (60%)
Satellite Campus – Cape Town	Second year = 17	n = 10 (60%)
TOTAL	**74**	**n = 44 (100%)**

Table 1.2: Sample size of nursing students

Name of institution	Population size of nursing students	Sample
Main Campus – Thaba Tshwane	First year = 101	n = 61 (60%)
Main Campus – Thaba Tshwane	Second year = 69	n = 41 (60%)
Main Campus – Thaba Tshwane	Fourth year = 44	n = 26 (60%)
TOTAL	**214**	**n = 128 (100%)**

The total number of nurse educators at the three different nursing colleges was 55. The sampling process was exactly the same as for the selection of the nursing students and pupil enrolled nurses. The researcher will include 60% (n=34) of the total population of nurse educators in the research study as revealed in table 1.3.

Table 1.3: Sample size of nurse educators respective to the different campuses

Name of institution	Population size of nurse educators	Sample
Main Campus – Thaba Tshwane	43	n = 26 (60%)
Satellite Campus – Bloemfontein	6	n = 4 (60%)
Satellite Campus –Cape Town	6	n = 4 (60%)
TOTAL	**55**	**n = 34 (100%)**

The professional nurses employed in all three military hospitals came to a total of 636. The sampling procedure was exactly the same as for the selection of nursing students and pupil enrolled nurses. To ensure that an equal proportion of professional nurses from each hospital were included in the study the researcher used 60% (n=382) of the total number of professional nurses from each military hospital as stated in table 1.4.

Table 1.4: Sample size of professional nurses respective to the different campuses

Name of institution	Population size of professional nurses	Sample
1 Military Hosp – Thaba Tshwane	471	n = 283 (60%)
2 Military Hosp – Cape Town	108	n = 65 (60%)
3 Military Hosp–Bloemfontein	57	n = 34 (60%)
TOTAL	**636**	**n = 382 (100%)**

1.8 PILOT STUDY

The questionnaires used in the proposed study were tested by the researcher under the same circumstances as the original study in order to peruse the study for any vagueness and shortcomings.

The questionnaires were presented to nurse educators, professional nurses, nursing students and pupil enrolled nurses at the Thaba Tshwane and Bloemfontein campuses of the SAMHS as shown in table 1.5.

Table 1.5: Sample taken from different categories of nurse educators and professional nurses

Name of institution	Population size of health care professionals in the South African Military Health Service utilized in pilot study	Total
Main Campus – ThabaTshwane Satellite Campus – Bloemfontein	Nurse educators: 4 Nurse educators: 1	5
1 Military Hosp – Thaba Tshwane 3 Military Hosp – Bloemfontein	Professional nurses: 3 Professional nurses: 2	5
Main Campus – Thaba Tshwane	1st year Nursing students: 1 2nd year Nursing students: 1 4th year Nursing students: 2	4
Satellite Campus – Bloemfontein	Pupil enrolled nurses: 5	5
TOTAL	**n=20 (100%)**	**19**

The researcher decided to conduct the pilot study mainly at the main campus because of the availability of three of the four categories of health care professionals within one campus.

1.9 DATA COLLECTION

Primary data for the specific study was collected by the researcher through completion of self-administered questionnaires by respondents (cf Bless et al., 2006:111). The researcher was actively involved in the data gathering process through the distribution and collection of questionnaires (Burns and Grove, 2009:441; De Vos et al., 2011:206).

The researcher obtained permission from the departmental heads of the different nursing colleges situated in Thaba Tshwane, Bloemfontein and Cape Town as well as from the chief matrons and chief executive officers of 1, 2 and 3 military hospitals, the

Military Health Ethics Committee and the Ethical Committee of the Faculty of Health Sciences before proceeding with data collection.

Due to the fact that the official language policy of the Department of Defense is English, the researcher compiled questionnaires that adhere to the policy. Questionnaires were typed and duplicated beforehand.

The researcher prepared a venue where respondents could sit down to complete the questionnaires. The availability of the researcher was stipulated as follows:

a. 1st session: 08:30-09:30
b. 2nd session: 10:30-12:30
c. 3rd session: 14:00-15:00

The researcher personally distributed the questionnaires to the respondents, who completed the questionnaires. The estimated time for completion of a questionnaire was set at approximately 30 minutes. After the respondents had completed the questionnaires, the researcher collected these and checked that each questionnaire had been completed as required.

1.10 VALIDITY

High content validity pertains to an instrument that can measure all the different components of the variable in question (Babbie and Mouton, 2009:123; Bless et al., 2006:157; De Vos et al., 2011:173) whereas face validity deals with the way the instrument manifest itself to the respondent (Babbie et al., 2009:122; Bless et al., 2006:160; De Vos et al., 2011:173).

The researcher utilized the expertise of the supervisor, professionals in research methodology and statisticians to scrutinize the questionnaires before distribution. A

pilot study was conducted to test the adequacy of the questionnaires and to assess the feasibility of the proposed study.

1.11 RELIABILITY

The reliability of the questionnaires in the study were enhanced by selecting questions from existing literature and by ensuring that enough questions were included to reach the purpose and objectives of the study.

1.12 ETHICAL ISSUES

Authorization for conducting the research firstly was obtained from the Ethical Committee of the Faculty of Health Sciences. Thereafter the researcher obtained permission from the Military Health Ethics Committee, the chief executive officers of the various military hospitals, the Officer Commanding of the South African Military Health Service nursing colleges, the Officer in Charge of each nursing college as well as the respondents who will participate in the survey.

Each questionnaire was accompanied by an explanatory letter stating the purpose of the research and inviting each respondent to complete the questionnaire voluntarily and anonymously. It was made clear that withdrawal from the study could take place at any stage of the survey and that respondents were free to do so without any consequences.

The researcher maintained confidentiality throughout the survey and did not disclose any particulars of any one of the respondents or institutions who participated in the research study. The researcher, statistician and the supervisor were the only persons who had access to the completed questionnaires. The data gathered was not made available to any unauthorized person. After data analysis the results will be published in a report and copies of the report will be made available to the respondents on request.

Remuneration was not granted to any of the respondents.

The potential benefits for all respondents in the study are such that the information gathered from the respondents will be utilized to develop clinical supervision programmes.

The research results will be published in a scientific journal through the UFS's School of Nursing.

1.13 DATA ANALYSIS

A descriptive statistic method was used for the proposed quantitative research study (Brink et al., 2008:171; De Vos et al., 2011:251). Descriptive statistics, namely means, standard deviations and percentiles were calculated for continuous data. Frequencies and percentages were calculated for categorical data. The analysis was performed by the UFS's Department of Biostatistics.

1.14 VALUE OF THE STUDY

The proposed research has value for the departments of all three military nursing colleges seeing that the research findings will be used to improve clinical supervision by various military health care professionals. After conduction the research, the researcher made certain recommendations on how clinical supervision in the military milieu can be improved. The research results will be published in a scientific journal through the UFS's School of Nursing.

1.15 REFERENCES

BABBIE, E. AND MOUTON, J. 2009. The practice of social research. 9th ed.: Cape Town: Oxford University press Southern Africa.

BLESS, C., HIGSON-SMITH, C. AND KAGEE, A. 2006. Fundamentals of social research methods. 4th ed. Cape Town: Juta & Company.

BURNS, N. AND GROVE, S.K. 2009. The practice of nursing research. 6th ed. Philadelphia: Saunders.

BRAMMER, J.D. 2008. RN as gatekeeper: gatekeeper as monitoring and supervision. *Journal of Clinical Nursing*, 17(14):1868-1872.

BRINK, H., VAN DER WALT, C. AND VAN RENSBURG, G. 2008. Fundamentals of research methodology for health care professionals. 2nded. Cape Town: Juta & Company.

BRYANT, L. 2010. Clinical supervision. *Practice Nurse,* 39(12):36-41.

CARRIGEN, C. 2012. A clinical issue: training our future nurses. *Australian Nursing Journal,* 20(2):22-25.

COUGAR, J.P. 2010. Nurse educator definition. e How Contributor [online]. Available from: http://i.ehow.com/image/a06/3b/d4/nurse-educator-definition-1.1-800x800.jpg [Accessed 03 September 2010].

CROXON, L. AND MAGINNIS, C. 2009. Evaluation of clinical teaching models for nursing practice. *Nurse Education in Practice,* 9(4):236-243.

DEMPSEY, R., CUTHEL, A. AND McMENAMIN, M. 2012. Supervising in organisations. *Healthcare Counseling and Psychotherapy Journal*, 12(1):4-10.

DE VOS, A.S., STRYDOM, H., FOUCHé, C.B. AND DELPORT C.S.L. 2011. Research at grass roots. 4th ed. Pretoria: Van Schaik.

FOWLER, J., FENTON, G. AND RILEY, J. 2007. Using solution-focused techniques in clinical supervision. *Nursing Times*, 103(22):30-31.

GOPEE, N. 2008. Mentoring and supervision in healthcare. Great Britain: SAGE.

KILMINSTER, S., COTTRELL, D., GRANT, J. AND JOLLY, B. 2007. Effective educational and clinical supervision. *Medical Teacher*, 29(1): 2-19.

LöFMARK, A., THORKILDSEN, K., RäHOLM, M. AND NATVIG G.K. 2011. Nursing students' satisfaction with supervision from preceptors and teachers during clinical practice. *Nurse Education in Practice*, 12(3):164-169.

LYNCH, L., HANCOX, K., HAPPELL, B. AND PARKER, J. 2008. Clinical supervision for nurses. Singapore: Wiley.

MABUDA, B.T., POTGIETER, E. AND ALBERTS, U.U. 2008. Student nurses' experiences during clinical practice in the Limpopo Province. *Curationis*, 31(1):19-27.

MACKENZIE, K.M. 2009. Who should teach clinical skills to nursing students? *British Journal of Nursing*, 18(7): 239-240.

MOCHAKI, N.W. 2007. Real learning. *Nursing Update*, 31(2): 32-35.

PILLAY, P. AND MTSHALI, N.G. 2008. Clinical supervision and support for bridging programme students in the greater Durban area. *Curationis,* 31(4):46-56.

SOUTH AFRICAN NURSING COUNCIL. 2006. *Nursing Act No. 33 of 2005.* Government Gazette, 28883:491, May 29.

SOUTH AFRICAN NURSING COUNCIL. 1993. *Regulation relating to the course leading to enrolment as a nurse.* Regulation R2175 in terms of the Nursing Act, 2005, Act no 33 as amended. Pretoria: Government Printers.

SOUTH AFRICAN NURSING COUNCIL. 1985. *Regulation relating to the approval of and the minimum requirements for the education and training of a nurse (General, Psychiatric and Community) and Midwife leading to registration.* Regulation R425 in terms of the Nursing Act, 2005, Act no 33 as amended. Pretoria: Government Printers.

WALDOCK, J. 2010. Facilitating student learning in clinical practice. *Kai Tiaki Nursing New Zealand,* 16(1):14-16.

WALKER, J. 2009. Examining the benefits of professional clinical supervision. *Kai Tiaki Nursing New Zealand*, 15(5):12.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The nursing profession is a skill-based profession (Gopee, 2008:66; Henderson, 2011:4) which implies that teaching and learning direct nursing professionals to become competent when executing specific clinical interventions (Gopee, 2008:66; Moscaritolo, 2009:17). A skill signifies having knowledge and experience in an activity which has been developed as the result of training and repetition (Fotheringham, 2009:387) enabling the individual to perform the particular task with efficiency and flexibility (Curzon, 2004:290). All nurses, regardless of their professional designation or speciality, are expected to possess certain basic skills (Fotheringham, 2009:387). Nursing students and pupil enrolled nurses need to practice and develop these basic skills through clinical supervision in order to equip themselves for their future roles in a dynamic health care environment (Dickson, Walker and Bourgeois, 2006:416; Kilminster, Cottrell, Grant and Jolly, 2007:7; Zilembo and Monterosso, 2008:194).

The ultimate aim of clinical supervision is to assist nursing students in the clinical learning environment to become confident qualified professional- or enrolled nurses. Since traditional clinical supervision does not provide students with enough opportunities to work on their own, they do not have the necessary self-confidence in their nursing skills and are therefore not acquainted with the day to day reality of nursing subsequent to completion of their clinical practicum (Jiang, Chou and Tsai, 2012:152).

In chapter 2 the modified conceptual framework is used to guide the discussion on clinical supervision and to provide a theoretical foundation on which the two questionnaires were based. In the context of this study the three key dimensions identified in the conceptual framework are regarded as crucial for clinical supervision and should be in place for it to be effective.

2.2 CLINICAL SUPERVISION

Clinical supervision has been defined by Dolling and Rogers (2011:4) as “a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations”.

2.3 KEY DIMENSIONS FOR CLINICAL SUPERVISION

The clinical supervision conceptual framework that is used in the research study was modified from Pillay’s and Mtshali’s (2008:48) conceptual framework which they adjusted from the Hyrkäs model (2002:50) and has three key dimensions, namely clinical supervision prerequisites, the core of clinical supervision and the outcomes of clinical supervision. Each of the three dimensions was sub-divided to include important concepts.

2.3.1 Key dimension 1: Clinical supervision pre-requisites

Clinical supervision prerequisites or antecedents refer to conditions that should be created ahead of the implementation of clinical supervision (Pillay and Mtshali, 2008:48). Conditions listed by the same authors are finances, human resources, time and place.

2.3.1.1 Resources

One of the biggest threats to the occurrence of clinical supervision, mentioned by Pillay and Mtshali (2008:49) is a lack of resources. Resources included persons, assets, material or funds which can be utilized to accomplish a goal in an organization. In relation to clinical supervision prerequisites, the researcher has addressed financial and human resources, time, workload and workplace.

2.3.1.1.1 Financial resources

Although nurse educators have to be aware of the importance to mange financial resources in an organization, a discussion on financial resources will not form part of this study.

2.3.1.1.2 Human resources

Human resources can be defined as “people that staff and manage an organization as contrasted with the financial and material resources of an organization.” (Heathfield, 2012:Online). In the context of this study and considering clinical supervision in the South African Military Health Service, human resources refer to professional nurse educators, professional nurses, nursing students and pupil enrolled nurses.

- *Nurse educators and professional nurses*

A nurse educator is a qualified registered nurse who lectures and guides students who prepare themselves to enter the nursing profession (Cougar, 2010: Online). The number of nurse educators in the SAMHS at the time of the research came to a total of 55.

Professional nurses refer to individuals who are qualified and registered with the SANC to practice nursing autonomously and who are competent to engage in responsibility and accountability for the practice (SANC. *Government Gazette*, 2006:34). A total of 636 professional nurses are employed in the SAMHS at the time of research.

The appointment of suitable clinical supervisors i.e. nurse educators and professional nurses, is important because it influences the clinical environment of students (Quinn and Hughes, 2007:345). Nurse educators and professional nurses in the SAMHS are appointed by the headquarters of this organisation. Appointed employees receive duty sheets from departmental heads in the different military hospitals in which it stipulates

that clinical supervision with students form part of the duties that need to be executed as required and specified by the SANC.

The Strategic Plan for Nursing Education, Training and Practice (2012/13-2016/17:30) stipulates that in order to meet the needs of nursing education, a national nurse educator development framework is necessary to ensure adequate numbers of appropriately qualified nurse educators in both clinical and theoretical spheres of nursing. Furthermore the primary aim of nursing education and training must be to provide sufficient numbers of competent, caring nurses to meet the health needs of all South Africans. Nursing education and training programmes should be coordinated with health service delivery needs while ensuring that qualifications obtained correspond with the scopes of practice and relevant legislation (Strategic Plan for Nursing Education, Training and Practice (2012/13-2016/17:28).

Considering clinical supervisor and student ratios global standards recommend student groups of not more than 15 and preferably nurse educator-student ratios of 1:15-20 for pre-registration clinical training and supervision (Strategic Plan for Nursing Education, Training and Practice, 2012/13-2016/17:74). The current nurse educator-student ratio for pre-registration clinical training and supervision is 1:15 at the main campus in Thaba Tshwane, 1:5 at the nursing college in Cape Town and 1:4 and at the nursing college in Bloemfontein.

- *Nursing students and pupil enrolled nurses*

A nursing student can be defined as an individual who is registered for a four-year nursing course leading to registration as a nurse (general, psychiatric, community and midwifery) according to the SANC Regulation R425 of 22 February 1985, as amended.

Pupil enrolled nurses can be defined as individuals who undertake nursing education and training at an approved nursing institution that leads to enrolment as a nurse according to the SANC Regulation R2175 of 1993 as amended.

The main campus situated in Thaba Tshwane has a total number of 214 first-, second- and fourth year nursing students at the time of the research, while the two campuses in Cape Town and Bloemfontein have 40 pupil enrolled nurses respectively. A total number of 260 student posts are available at the main campus in Thaba Tshwane and each campus had 40 student posts. At the time, 277 nursing students were being trained at the main campus and therefore no vacant student posts exist in any of the nursing colleges.

The selection criteria used to select nursing students in the SAMHS are as follows:

- the minimum M-score for the 4 year nursing course is 14
- the minimum M-score for the 2 year nursing course is 8-12
- if the prospective candidate has an M-score between 12-13 and has endorsement, the candidate may be selected for the 4 year nursing course and if not endorsed then the candidate may be selected for the 2 year nursing course
- Life-orientation may not be disregarded when calculating the M-score
- all prospective nursing students must have Biology (Life Sciences), Mathematics and/or Maths Literacy and English as compulsory subjects
- an English pass rate of at least 4 points

Successful clinical supervision depends on student characteristics. Pillay and Mtshali (2008:50) state the following: “Certain specific personal characteristics of the students are important for effective clinical supervision. This can be summarized in terms of demographics, motivation to learn, self-confidence and willingness to acquire feedback.”

2.3.1.2 Clinical learning environment

According to Dunn and Burnett (1995:1166) as cited in Stuart (2004:186) a clinical learning environment can be defined as an “interactive environment of forces within the clinical setting that influence the students’ clinical learning outcomes.”

A workplace setting or better known as a clinical learning environment is an essential and irreplaceable resource (Beskine, 2009:35; Hartigan-Rogers, Cobbett, Amirault and Muise-Davis, 2007:2; Mackenzie, 2009:243; Moscaritolo, 2009:17) that provide students with the opportunity to apply their theoretical knowledge to practice (Henderson, Twentyman, Eaton, Creedy, Stapleton and Lloyd, 2009:178; Pillay and Mtshali, 2008:47; Sedgwick and Yonge, 2008:2; Taylor; 2009:61) to master essential skills (Henderson et al., 2009:177; Hunter, 2011:Online; Sedgwick and Yonge, 2008:2; Teepa; 2011:35) and to achieve the required competencies for registration (Arja, Eriksson, Meretoja, Sillanpää and Rekola, 2007:382; LaFauci, 2009:1).

The clinical learning environment therefore serves as a formal educational setting and must not only be seen as a physical environment where patient care and other clinical activities can take place. It also needs to be seen as an environment that includes material resources, formal requirements, culture, procedures, nursing standards and practices of the clinical working place, expectations and interactions of all the people who are in it, as well as the personalities of all the individuals who form part of the environment (Stuart, 2004:186).

Exposure of students to the clinical environment is considered by some as the most stressful component of the nursing program (Andrews, Brodie, Andrews, Hillan, Thomas, Wong and Rixon, 2006:861; Moscaritolo, 2009:17). Students may experience anxiety due to a number of factors (Andrews et al., 2006:862; Beskine, 2009:37; Maginnis and Croxon, 2010: Online; Moscaritolo, 2009:17; Warren, 2010:1364). These factors might include the fact that it could be the first clinical experience, that they are scared to make mistakes when executing clinical skills or clinical assessments. Other factors that might contribute to students anxiety are a lack of support by nurse educators and professional nurses, the theory-practice gap (Moscaritolo, 2009:17), incompetency, difficult patients, unfamiliar areas and insufficient knowledge and professional nursing skills for taking care of patients in the clinical setting (Cooper, 2009:71). The fear experienced may either encourage students to practice clinical skills

to become competent, or it can affect students' theoretical and practical performance in such a way that it results in inadequate coping skills (Moscaritolo, 2009:22).

In order to address these fears a clinical learning environment conducive to learning should meet certain criteria, e.g., it should provide learning experiences for students in order to facilitate the development of the required knowledge and skills. At the same time students should have particular personal characteristics for effective clinical supervision to take place, such as self-confidence, motivation to learn and willingness to acquire constructive feedback (Pillay and Mtshali, 2008:50). The practical setting should preferably portray respect for students' distinctiveness and their abilities. It does not imply that an existing educational situation should change to demonstrate a false feeling of affiliation where differences of opinion cannot be expressed. It must be kept in mind that differences in opinions, perspectives and reasoning are part of the learning process. Conflict, however, is an important learning tool and improve students' reasoning skills and their existing knowledge (Meyer and Van Niekerk, 2008:107).

Furthermore, the learning climate should be humanistic, authentic, supportive and caring, but also stimulating and disciplined in the search of new knowledge. Being sensitive and caring about students' needs does not imply comprising on the quality and standard of performance but simply means considering strategies that are aimed assisting students in the achievement of the desired outcomes. Students ought to have a professional person that is acquainted with their academic and professional safety needs that will utilize all possible opportunities when guiding students to become safe, competent professionals (Meyer and Van Niekerk, 2008:107).

The most effective professional person to create a humanistic climate, namely the nurse educator should display qualities such as a non-judgemental attitude, generosity, confidence and honesty and a willingness to take risks and be in the lead without showing off. They should furthermore be motivated to educate students (Meyer and Van Niekerk, 2008:107).

Another crucial issue that affects supervision of students in the clinical setting is the willingness of professional nurses and educators to take on the role (Arja et al., 2007:381; Carlson, Pilhammar and Wann-Hansson, 2010: 436; Fitzgerald and McAllen, 2007:465). Nursing students and pupil enrolled nurses depend on professional nurses to support, supervise, teach and assess them in practice in order to allow them to gain knowledge and become skilled in a secure and supportive environment (Brammer, 2008:1868; Henderson et al., 2009:178). Even though nurse educators depend largely on professional nurses to optimally enhance students' learning environment, the latter task remains primarily that of the nurse educator and the training institution (Meyer and Van Niekerk, 2008:107).

Unfortunately factors that have a negative influence in the clinical learning environment have also been described in literature. Examples include, students that are not inspired to achieve their learning outcomes in the clinical learning environment, causing professional nurses to have a tendency to devote less time and effort in clinical teaching (Hardy, 2009:71) and professional nurses that are not motivated and are not concerned with student supervision and learning in the clinical setting (Brammer, 2006:969; Vallant and Neville, 2006:31). In situations where inexperienced and relief professional nurses (Waldock, 2010:15) as well as former students who just completed their training (Brammer, 2008:1870; Henderson and Tyler, 2011:289) are required to supervise students, a learning environment is not created because these professional nurses are not capable of assisting and supporting students in meeting their outcomes or reflect or effectively reflect on practice. Furthermore professional nurses that do not display clinical teaching skills cannot be considered role models for students (Andrews et al., 2006:862).

If a clinical learning environment is rich in learning opportunities, but exclude an active and enthusiastic professional nurse for clinical supervision, nursing students may be discouraged to make use of the available learning opportunities.

- *Workload and time*

A heavy workload, due to personnel shortages and insufficient time for completing nursing tasks, have been recorded as two of the most important reasons for the unwillingness of professional nurses to supervise students (Frankel, 2008:5; Henderson, Fox and Malko-Nyhan, 2006:133; Kemper, 2007:10; McGowan, 2006:1102; Taylor, 2009:61; Vallant and Neville, 2006:28). Professional nurses perceive the presence of students in the clinical learning environment as an additional responsibility (Andrews et al, 2006:861; Kemper, 2007:10) and are of opinion that a substantial amount of work limits the learning opportunities at their disposal (Eta, Atanga, Atashili and D'Çruz, 2011:1; Vallant and Neville, 2006:27).

Intensification in the clinical condition of patients in the clinical setting causes a heavy workload for professional nurses as well as limited amount of time to spend with their patients. These circumstances are exacerbated by the inadequate number of professional nurses, which left them feeling stressed and overburdened (Carayon and Gurses, 2008:Online; Kemper, 2007:10). On top of this complex situation, the presence of students in the clinical learning environment can be enough to make the difference between managing and not managing the assigned workload (Brammer, 2006:965). A result of a heavy workload is a low morale and an opposing approach towards students (Andrews et al., 2006:865; Carayon and Gurses, 2008: Online). This oppositional attitude may be noticed where students display a tendency to be sluggish in the execution of specific tasks and professional nurses then consider it to be faster and simpler to complete these tasks themselves (Lillibridge, 2006:49; Vallant and Neville, 2006:27). While the duty of patient care and safety remains the responsibility of professional nurses, it seems as if the heavy work load in the clinical environment incline to decrease the time to teach and to get involved in critical thinking (Henderson et al., 2006:134).

Professional nurses often mention that insufficient time to complete their own clinical work is a hindrance to them as well as their growing unwillingness to engage in extra nursing duties such as continuous student supervision (Henderson et al., 2006:134).

Students in the clinical learning environment often blame themselves for the opposing attitude of professional nurses towards them that lead to inadequate functioning (Sims, 2009:33).

2.3.1.3 Agreement between clinical supervisor and nursing students

A learning agreement or contract can be defined as a written and signed agreement between a nurse educator and a student resulting in the latter's active involvement in decisions over practice outcomes and other components of learning (Gopee, 2008:26).

The said contract between the clinical supervisor and the nursing student is regarded the crux of clinical supervision. The agreement or contract describes the practical measures such as the period of time of clinical supervision, rules, roles, responsibilities and expectations throughout the teaching learning process (Pillay and Mtshali, 2008:50). Other attributes of learning contracts are that it serve as useful tools for the development of a student's independency in the clinical learning environment (Quinn and Hughes, 2007:367) and that the integration of learning is promoted (Quinn and Hughes, 2007:30).

A basic principle of adult teaching and learning, namely students' active involvement in the learning process, is addressed through the use of agreements or contracts. Previously nurse educators prescribed the outcomes, content, methods of learning and assessment of a curriculum without taking students decisions into consideration. More recently adult teaching and learning include negotiation of certain aspects of the curriculum. Negotiation involves mutual agreement between the nurse educator and the student and is therefore more than just a symbol of students' involvement (Quinn and Hughes, 2007:109). Learning contracts give students some control over the outcomes, content, methods and assessment stipulated in the curriculum (Quinn and Hughes, 2007:30).

2.3.2 Key dimension 2: The core of clinical supervision

The core of clinical supervision comprise of various important issues such as clearly stated outcomes for each clinical supervision session, a teaching-learning process that facilitates the achievement of expected outcomes, a relationship between the supervisor and the student that promotes learning and lastly the availability of time for clinical supervision (Pillay and Mtshali, 2008:50). In the conceptual framework designed for the study, the last issue, namely the availability of time for clinical supervision was replaced with practice-orientated learning experiences and the supervisory role.

2.3.2.1 Outcomes of clinical supervision

The outcomes of clinical supervision refers to the outcomes that students have to achieve at the end-stage of student learning and depicts the knowledge, skills, attitudes and values that students need to obtain due to the educational process. Learning outcomes are obtained from the educational outcomes of a programme and are described according to the capabilities that students have to accomplish in order to be competent (Quinn and Hughes, 2007:112).

The important task is laid upon nursing professionals to formulate outcomes that will eventually enable students to provide safe and effective care to patients, to integrate knowledge, skills and attitudes and to make sound judgment decisions (Studymode, 2008:Online). Extensive nursing knowledge that includes physiology, pharmacology, knowledge of legal issues and nursing theories is needed for effective critical thinking, clinical judgment and decision-making.

The scope of practice of professional nurses most certainly requires that nurses are competent to execute clinical tasks such as physical assessments and diagnosis and administering of injections and medications, to ensure safe patient outcomes. Attitudes on the other hand have affective, cognitive and behavioural components. A competent student needs to have the ability to perceive and recognize a situation, the

tendency to act in a controlled and predictable manner and lastly the ability to be consistent in acting in a manner relevant to the situation (Studymodez, 2008: Online).

To achieve the above, one should consider the fact that the practice of nursing has developed in such a way that it has left many students working with minimal clinical supervision (Brammer, 2008:1868; Croxon and Maginnis, 2009: 240; Ellis, 2010:107; Pillay and Mtshali, 2008:48; Zilembo and Monterosso, 2008:203). Consequently it places an immense responsibility on the nurse educators and professional nurses to see to it that the students are competent (Cassimjee and Bhengu, 2006:47; King, Jackson, Gallagher, Wainwright and Lindsay, 2009:135; Pillay and Mtsali, 2008:47) and performs at a level relevant to their experience (Kilminster et al., 2007:6; Mabuda, Potgieter and Alberts, 2008:24). The most important aspects of clinical supervision are that it should ensure patient safety in the course of clinical care and promote professional development (Bryant, 2010:36; Ellis, 2010:36; Kilminster et al., 2007:6) to allow nurses to attain the knowledge and skills they require to practice effectively (Bryant, 2010:36; Ellis, 2010:97).

Lastly, nurse educators and professional nurses are more capable to educate, assess and support the accomplishment of students' learning outcomes when they are familiar with the curriculum (Altmann, 2006:1; Williams and Irvine, 2009:481). It involves supporting students to utilize their theoretical knowledge in the clinical practice in order to help them bridge what is commonly termed the theory-practice gap.

The issues described as part of the core of clinical supervision are essential prerequisites to promote high quality nursing care and therefore the researcher aims to identify the views of nurse educators, professional nurses, nursing students and pupil enrolled nurses that may influence the effectiveness of clinical supervision in the SAMHS.

2.3.2.2 The teaching and learning process

Teaching can be defined as “to tell or show, to give instructions or lessons in” or “to enable a person to do something by instruction and training” (Gopee, 2008:62). Learning on the other hand is a process which guides students to change in behavior through activities and experiences or it may refer to the achievement of new abilities or responses which are additional to natural development, growth and maturation (Gopee, 2008:42).

Gopee (2008:43) describes two contrasting perspectives on teaching and learning, which are identified as the “banking concept” versus “problem posing.” The banking concept refers to the traditional mode of learning where a nurse educator or professional nurse help students to fill their minds with knowledge, which is later “cashed out” fairly unchanged, for example in examinations. The “problem-posing” approach to education pertains to education through dialogue. Nurse educators, professional nurses and students meet to exchange ideas and experiences by means of critical discussions and debates (Gopee, 2008:43).

Professional nurses acknowledge their responsibility to teach in the professional practice. The Australian Nursing and Midwifery Council (2005:4) proclaims that professional nurses “contribute to the professional development of self and others”. It therefore requires that professional nurses need to teach other nursing categories such as nursing students, pupil enrolled nurses and other health disciplines when the time is suitable (cf Henderson and Tyler, 2011:290).

The Canadian Nurses Association (2009:2) stipulates that professional nurses have to provide constructive feedback to coworkers as one of 44 requisite competencies. Nurses who are aware of this responsibility and therefore facilitate teaching and learning of their colleagues, play a part in the establishment of clinical learning environments where all personnel engage in the development of others (McNamara, 2007:1521; Henderson, 2011:4).

There are real benefits to be gained if collectively all nurses are involved in teaching. This is particularly relevant when given increasing numbers of student nurses and therefore greater demands for learning opportunities in the clinical practice setting (Henderson and Tyler, 2011:290).

2.3.2.3 The relationship between clinical supervisors and nursing students

Quality working relationships amongst nurse educators, professional nurses and students in the clinical learning environment are essential to ensure continuous learning and to promote an emotional connection between them (Levett-Jones, Lathlean, Higgins and McMillan, 2008:13). A warm welcome, good working relationships (Beskine, 2009:37; Levett-Jones et al., 2008:14; Zilembo and Monterosso, 2008:201) and being acknowledged by professional nurses will assist students to settle in the clinical environment and better learning outcomes (Beskine, 2009:37; Vallant and Neville, 2006:27). The relationship between professional nurses and students develop over a period of time and are affected by communication, eagerness to complete tasks (Cooper, 2009:71), prior clinical experience and the way they approach each other (Andrews et al., 2006:863).

2.3.2.4 Practice-orientated learning experience and supervisory role

The teaching-learning process entails practice-orientated learning experiences for students on a daily basis, whilst the supervisory relationship refers to the interaction that occurs between the clinical supervisors and students and is seen as the key element of clinical supervision (Pillay and Mtshali, 2008:50).

2.3.2.4.1 Practice-orientated learning experience

In the clinical learning environment where patients have varied needs, clinical supervision of students require thorough planning so that suitable learning opportunities can be accomplished (Stuart, 2004:195). Exploiting students as an additional pair of

hands may possibly seem convenient to professional nurses but it display hardly any understanding of the students' supernumerary status (Beskine; 2009:35; Cooper, 2009:70). A number of professional nurses prevent students from retrieving learning opportunities because of their negative influence on students (McGowan, 2006:1100; Vallant and Neville, 2006:31). It happens when professional nurses send students to perform nursing duties they can achieve autonomously, while the professional nurses concentrate or attend to more intricate tasks, thus preventing students access to learning opportunities (McGowan, 2006:1102; Vallant and Neville, 2006:28).

2.3.2.4.2 Supervisory role

The roles of the nurse educator have been unified and include teaching, supervision and assessment of students in the clinical learning environment. The question that arises is whether nurse educators should be the sole providers of clinical support, seeing that practice placements may add up to one half of a student's study programme (Quinn and Hughes, 2007:358).

According to Gerrish as cited in Quinn and Hughes (2007:358) three fundamental roles for nurse educators can be distinguished in the clinical setting. The first role pertains to the educational support rendered to nursing personnel and includes advice given with regard to the supernumerary status of students and support in the clinical setting for preceptors. Teaching of students is regarded as the second role and entails the facilitation of independency of students and their skills in reflective thinking. The last role is the facilitation of good practice and includes knowledge of the practical setting and development of a critical approach towards it (Quinn and Hughes, 2007:358).

- Role 1: Educational support

One of the components of a nurse educators' role is to assist and support students when implementing their knowledge and skills in practice (Hartigan-Rodgers et al.,

2007:1; Vallant and Neville, 2006:29) by means of rote modeling, clinical supervision and the facilitation of learning.

To render the educational support nursing students need, nurse educators must take their responsibility to be actively involved in the supervision of nursing students in the clinical setting seriously. A clinical training programme that includes preceptors, for example, professional nurses, should be developed and implemented. Preceptors that are well prepared will be more able to allow students to venture outside the "ward routine" in their search for knowledge and at the same time supervise and guide them in the clinical setting. A strong and supportive relationship with preceptors in the clinical learning environment will be required to achieve effective facilitation of learning (Meyer and Van Niekerk, 2008:108).

- Role 2: Teaching independency and reflective thinking

The professional nurse in the clinical learning environment has an informal teaching function. It entails the teaching of clinical procedures explicit to the ward**,** delegation of duties**,** to shape, interact, lead, give demonstrations, oversee, rectify, inspire**,** reiterate what has not been well understood at the nursing college**,** ask students about problems they might experience and resume with practical teaching where the nurse educator ended. The professional nurse does not only have an informal role as clinical teacher as stipulated in R425 of the South African Nursing Council, but also serve as a guidance counselor and preceptor (Cassimjee and Bhengu, 2006:50).

Nurse educators should definitely support and empower students to solve problems and to evaluate situations in the clinical learning environment, autonomously. Knowles (cited in Quinn and Hughes 2007:152) states that the traditional student role was previously that of dependency. However, students need not to be encouraged to become dependent when it comes to the learning of information, but should be expected to explore, inquire and argue about subject matter, apply new ideas and theories in practice and experiment with new methods of patient care. However care

should be taken that independent learning, experimentation as well as risk-taking behavior is promoted in the clinical learning environment and that students should be held liable for their actions and mistakes. Students are accountable to identify their abilities and limitations in clinical practice (Meyer and Van Niekerk, 2008:108) and must take responsibility not only for the rendering of quality patient care, but also for the completion of activities they have begun.

In the SAMHS nursing students and pupil enrolled nurses were perceived to be dependent on the nurse educator for planning and evaluating their teaching and learning and are therefore regarded as dependent and passive receivers of transmitted content. In contract learning, the role of the nursing student and pupil enrolled nurse shifts from passive receiver of transmitted information to that of an innovative planner and initiator of various approaches in order to achieve the mutually agreed outcomes (Quinn and Hughes, 2007:152).

- Role 3: Facilitation of good practice

According to Chapman and Orb (cited in Meyer and van Niekerk 2008:109) inadequate clinical supervision of students by nurse educators and preceptors is regarded as a negligent act. Optimal learning can only take place when a student is partnered with a clinical supervisor who shares their practical knowledge with them (Brammer, 2008:1874; Clynes and Raftery, 2008:407; Henderson et al., 2009:178; Leners, Sitzman and Hessler, 2006:2). It enables the student to see the purpose of the clinical observations made (Clynes and Raftery, 2008:407) and allow them to reflect on practice situations (Hartigen-Rogers et al., 2007:6). Several professional nurses only concentrate on the clinical demands of patients and tend to forget the importance of engaging students in valuable learning experiences during provision of nursing care (Henderson et al., 2009:178). Engagement of students in nursing care allows professional nurses to facilitate learning during clinical practice (Henderson et al., 2009:178; Newton, Billet and Ockerby, 2009:630).

To decrease nursing students' fears of making mistakes in the clinical learning environment, nurse educators have the responsibility to ensure that students received demonstrations in and practice of all the nursing procedures that they are required to perform at the relevant level of development. Preceptors are supposed to know the skills students already acquired, so that they can try to limit the possibility of over-exposure which could cause danger to patients. However, it must be taken into consideration that valuable learning opportunities must not be wasted just because students did not observe the demonstration beforehand. Direct exposure in the clinical learning environment remains an invaluable experience for nursing students if coupled with the presence and support of a competent and knowledgeable nurse educator (Meyer and van Niekerk, 2008:108).

If nurse educators and professional nurses are not sufficiently trained for student supervision, learning opportunities in the clinical setting are more task-orientated and the facilitation of learning does not transpire (Williams and Irvine, 2009:479).

2.3.2.4.2.1 Important aspects of clinical supervision

The clinical learning environment is characterized with many influences that can either enhance or undermine students' ability to incorporate knowledge and experience into practice. The factors that will be discussed include training, communication, support, theory practice gap, assessment and feedback.

- *Training*

Quality learning opportunities have to be arranged and provided to allow students to achieve learning outcomes and competencies. This could be achieved through the design of learning programmes in a manner that will enable students to apply their knowledge, understanding and skills during performance and provision of care required by patients. Mostly, however, nurse educators have the responsibility to ensure that

teaching and learning activities, including clinical experiences, support the student in achieving these competencies (Stuart, 2004:32).

Education and training institutions should carefully consider the capabilities, knowledge and skills when appointing professional nurses to supervise students (Williams and Irvine, 2009:475). Likewise is their attitude and preparedness to take up the supervisory role (Lillibridge, 2006:47). Experience in nursing cannot automatically be linked with competence in teaching (Altman, 2006:13) and therefore caution should be used when allocating professional nurses to the supervision role.

- *Knowledge*

Members of the nursing profession might share the opinion that teaching, learning and development transpire throughout their careers and that even the most skilled and knowledgeable nurse has a great deal to learn (Lynch, Hancox, Happell and Parker, 2008:5). Life-long learning is facilitated by a framework of competencies provided by clinical supervision, which enables professional nurses to develop the necessary knowledge and skills that are essential to be clinically competent to practice within a health care system (Jervis and Tilki, 2011:5821; Kilminister et al., 2007:7; Lynch et al., 2008:5).

Colleagues with expert knowledge of the latest research in their speciality areas and those who are aware of student's learning needs, their knowledge and competency levels, usually create a positive impression. The interest of colleagues who take up the responsibility to teach in the clinical setting together with the nurse educators' involvement, create impetus for learning. A culture in which personnel are open to new ideas and who communicate newly gained knowledge from courses also present healthy perspectives (Gopee, 2008: 85).

- *Skills*

According to Curzon (cited in Gopee 2008:66) nurses are skill-based professionals which imply that learning leads to competency when executing particular clinical interventions to improve patients' health. A skill necessitates effective mind and muscle co-ordination which results in the production of suitable, fast and meaningful patterns of movement.

Nurse educators and professional nurses have the responsibility to ensure that students have the required clinical experience and skills to develop professional competencies in such a way that the patient is not injured at all while the student is giving the care (Stuart, 2004:30).

- *Attitude*

Professional nurses are sometimes selected to supervise students grounded on personnel availability. It may cause them to experience feelings of unwillingness and incompetency for the supervisory role and result in frustration that may frequently be forwarded to students in the clinical learning environment (Brammer, 2006:1870).

- *Communication*

Effective communication, constructive comments on skill performance and being part of the nursing team are also considered essential elements of the clinical learning environment (Gopee, 2008:85). Nurse educators and professional nurses have the enormous responsibility and accountability to communicate efficiently and convey essential information correctly. When communication breaks down, so does nursing performance (Papa, 2011:Online) and it may lead to misconceptions, annoyance, mistakes and poor patient outcomes (Pope, Rodzen and Spross, 2008:42).

The establishment of a relationship in the clinical learning environment relies on good communication (Andrews et al., 2006:8640; Wilkes, 2006:46). Yet not everyone in the health care environment utilizes the correct modes of communication during clinical supervision (Wilkes, 2006:46). A bad encounter may transpire when professional nurses resentfully receive students, creating a feeling of rejection and depreciation (Brammer, 2006:1870; Henderson et al., 2006:12). Cook (cited in Vallant and Neville 2006:25) reported that professional nurses may be uninformed of the fact that their communication can negatively affect students and their functioning in the clinical learning environment. When preparing students for the rapid changing health care environment, nurse educators and professional nurses have the responsibility to share their knowledge and skills with students through effective communication.

In the provision of quality patient care, effective communication needs to be stressed and highlighted as vital for patient safety (Papa, 2011:Online; Jones, 2007:2299). Nurses and other health care professionals of the multidisciplinary team are compelled to improve their communication skills due to remarkable changes in the health care environment such as an increase in the number of highly acutely ill patients, severe nursing shortages and complex communication technologies (Miller, Riley and Davis, 2009:247).

Communication is important in providing safe and quality healthcare in the clinical setting and therefore it is necessary to ensure that every nursing student and pupil enrolled nurse are prepared and assessed on communication competency prior to exiting their program of study (Krautschied, 2008:1).

- *Support*

Kelly (2007:886) declared that an agreement could not be reached as to what constitutes appropriate support of clinical learning. For the purpose of this discussion, support will mostly refers to supportive relationships between all stakeholders in order to be able to provide effective clinical supervision.

In the health care environment nurse educators and professional nurses have a common function; namely, that of supporting students in the clinical setting (Vallant and Neville, 2006:24; Warren, 2010:1364). Once professional nurses understand what is essential to develop and promote student learning, they reveal a more supportive and encouraging attitude and are more prepared to take part in student learning (Andrews et al., 2006:871; Lillibridge, 2007:47).

To strengthen support amongst them, nurse educators and professional nurses should:

- work together as a team, particularly when students are present in the clinical setting (Andrews et al., 2006:872; Carlson et al., 2010:436). Because professional nurses liable for supporting students in the clinical setting, could be experiencing an excessive workload (Ehrenberg and Häggblom, 2007:71) the support rendered is especially important.

- liaise in the clinical setting to create a positive teaching climate for students and to act supportively in matters pertaining to educational achievement and performance (Sayers and Davidson, 2009:1; Taylor, 2009:61; Waldock, 2010:16).

Advantages related to collegial support and team work in the clinical setting include a reduction in the workload when it comes to patient care (Carlson et al., 2010:436). It will further enable professional nurses and students to spend more time together when engaging in valuable learning experiences (Carlson et al., 2010:436; Henderson, 2011:4). Through the support and guidance from a more experienced professional nurse, the student develops the ability to transfer learning into their framework of understanding of practice (Mannix et al., 2009:59). Support 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 (Fitzgerald and McAllen, 2007:464).

An opposed to the advantages, ineffective support unfortunately results in missed opportunities for student learning (Clynes and Raftery, 2008:407; Vallant and Neville,

2006:28; Waldock, 2010:16; Warren, 2010:1366). A major concern that is singled out by nurses in practice is the perceived lack of support and interest that exist for students amongst the nursing school, nurse educators, professional nurses and fellow workers (Bourbonnais and Kerr, 2006:1543; Taylor, 2009:61; Waldock, 2010:16).

- *The theory-practice gap*

Practicing nurses have spent a lot of time discussing the existence of a theory-practice gap (Allen, 2008:133; Baxter, 2007:104; Haigh, 2008:1; Stuart, 2004:19; Wilson, 2008:1). But what is the theory-practice gap? It refers to nursing as a discipline that is continuously subjected to change and development (Allen, 2008:133; Haigh, 2008:1).

Development includes the formulation of new theories and techniques that need to be verified. After verification the theories and techniques have to be put in practice in order to analyse and modify them (Haigh, 2008:1; Hanberg, Brown, Billings and Kowalski, 2006:248). Should it happen that the new theoretical concepts and techniques are not accepted by nursing practitioners in the clinical practice it may result in a theory-practice gap (Haigh, 2008:1; Hanberg et al., 2006:248).

The literature reveals that the theory-practice gap became not only a national (Peter, 2008:1) but also an international problem and the only solution to the problem is the implementation of clinical supervision. But unlike theoreticians that are of opinion that the theory-practice gap is unwanted (Hanberg et al., 2006:248; Wilson, 2008:1), Rafferty (cited in Allen 2008:134) and Haigh (2008:2) is convinced that it provides healthy pressure necessary to modify the clinical practice and expand nursing knowledge (Allen, 2008:134).

The theory-practice gap happens when theory being taught in the classroom and the experience of clinical practice do not correlate and seem to differ. The gap that is created put students in a predicament when they attempt to apply their newly gained knowledge in practice. Students believe that theoretical knowledge is more applicable

and understandable to them when they are granted opportunities to observe the application of principles by professional nurses (Allen, 2008:134).

Emphasis is therefore placed on the fact that knowledge taught in the classroom is only of value when it is relevant and can be applied in the clinical setting. The application of theoretical knowledge in the clinical setting is obtained through clinical supervision (Baxter, 2007:104; Scherer and Scherer, 2007:499-500; Stuart, 2004:19).

During clinical supervision of students, professional nurses have to be entrusted with the responsibility to bridge the theory-practice gap (Baxter, 2007:104; Scherer and Scherer, 2007:499; Stuart, 2004:19). It is important that nurse educators take cognizance of the fact that they must not expect students to spontaneously incorporate theoretical knowledge into the clinical setting (Stuart, 2004:19).

The theory practice gap may have several repercussions for students. First of all it may result in decreased optimal patient care due to inadequate nursing care rendered in the clinical practice (Baxter, 2007:104; Hanberg et al., 2006:248). Secondly, it is felt that time is being wasted to include or exclude newly verified clinical practices, derived from nursing research.

On the other hand bridging the theory practice gap might result in enhancement of patient care and controlled healthcare costs (Hanberg et al., 2006:248). It could also enhance both students' theoretical knowledge and the application thereof in the clinical setting.

- *Assessment*

Nurse educators are liable providing students with the general and the clinical outcomes for the year of study for each clinical department. Requirements coupled with clinical experiences as well as the methods of clinical evaluation and grading criteria should therefore be available in writing (Meyer and Van Niekerk, 2008:108).

During clinical placements, students' practice competencies or clinical skills are assessed by selected qualified nurse educators and professional nurses (Gopee, 2008:401; Skingley, Arnott, Greaves and Nabb, 2007:28). Assessment is needed to determine students' development, attainment of outcomes and learning needs. Ample opportunities for students to evaluate their own progress should also be provided (Meyer and Van Niekerk, 2008:108).

Numerous problems associated with the assessment of nursing students' clinical skills in the practical environment have been highlighted and recorded in the literature (Jervis and Tilki, 2011:583; Luhanga, Yonge and Myrick, 2008:227). Research done on assessment of clinical skills discloses that students are sometimes incorrectly granted a pass for practice competencies, without confirmation of their ability to perform the psychomotor skills skillfully and efficiently (Jervis and Tilki, 2011:582; Luhanga et al., 2008:229; Stuart, 2004:35).

The consequences of students' competencies being signed as pass without thorough assessment of the students' ability to perform the psychomotor skills are poor nursing practices and risky as well as futile care, which possibly will cause harm to a patients' health (Gopee, 2008:402; Stuart, 2004:35).

Assessments ought to be conducted in such a way that they are valid, trustworthy and feasible (Gopee, 2008:03). Pass or fail conclusions by assessors should be based on the way the students' perform the clinical skills and whether it correlates with the clinical procedures of the health care setting. Nurse educators and professional nurses that undertake the supervisory and assessment role in nursing are accountable for safe and effective patient care (Gopee, 2008:402; Stuart, 2004:36). As soon as assessors do not facilitate learning sufficiently, grant a pass for practice competencies without confirmation of students' ability to perform those skills, or fail to see his or her accountability in care delivery, unethical practice is considered (Gopee, 2008:402).

When students are assessed on a formal and informal basis, nurse educators have to discuss the evaluation results with students on a regular basis (Meyer and Van Niekerk, 2008:108).

- *Feedback*

Feedback on clinical performance of students is an essential facet of teaching and learning (Chur-Hansen and McLean, 2006:67; Clynes and Raftery, 2008:409; McKimm, 2009:158). It is an interactive process between the clinical supervisor and the student and the main aim is to give students a better perception of their performance in the clinical learning environment (Clynes and Raftery, 2008:405; McKimm, 2009:158).

Feedback can be either constructive/negative or reinforcing/positive (Chur-Hansen and McLean, 2006:68; Clynes and Raftery, 2008:406). The purpose of constructive and reinforcing feedback is to assist and support students to determine their skills, expertise and strengths, as well as fields that still need professional development (Chur-Hansen and McLean, 2006:67; McKimm, 2009:158). Feedback intends to better the learning process, instead of forwarding judgment about a student's competence (Chur-Hansen and McLean, 2006:67; McKimm, 2009:160).

Regardless of the importance of giving feedback regularly and continuously, students reported that they do not receive sufficient feedback on their daily performance. Insufficient time is quoted as one of the causes for the incapability of professional nurse to provide feedback (Chur-Hansen and McLean, 2008:68). Research has revealed that clinical supervisors sometimes experience uneasiness when giving negative or constructive feedback about what students need to improve (Clynes and Raferty, 2008:407; Gopee, 2008:155). They may feel that they are being judgmental, and that constructive feedback will possibly harm the student-supervisor relationship (Clynes and Raftery, 2008:407).

Once nurse educators and professional nurses supervise students in the clinical practice, they have the responsibility to indicate to the students their personal growth and development. Therefore students' progress during clinical practice needs to be cautiously tracked and feedback given, so that they may be able to learn and develop further (Stuart, 2004:182).

2.3.3 Key dimension 3: Outcomes of clinical supervision

The outcomes of clinical supervision can be associated with the development of the student academically (knowledge, skills, attitudes and values) professionally and personally (Pillay and Mtshali, 2008:49).

According to Kotze (cited in Meyer and Van Niekerk, 2008:82), nurse educators have the responsibility to do all in their power to develop students as professional, responsible nurse practitioners. The development entails structured teaching and clinical supervision and has to accommodate the learning needs of students (Meyer and Van Niekerk, 2008:82).

The regulations and minimum requirements of the pre-registration course in nursing include all the requirements for enhancing the professional and personal growth of students in becoming independent, safe and professional nursing practitioners. The South African Nursing Council Regulation R425 regarding the approval of and minimum requirements for, the education and training of a nurse (general, psychiatric and community) and midwife that leads to registration (based on Regulation R753) place emphasis the meaningful integration of theory into practice with regard to every nursing subject. It also stresses the need for nurse educators to create meaningful learning opportunities and experiences which students can utilize to correlate theory and practice (Meyer and Van Niekerk, 2008:83).

Academic development pertains to knowledge and cognitive abilities, namely thinking skills that improve independent problem-solving and the rendering of quality nursing

care. During student supervision, the nurse educator or clinical supervisor gives structure to students' professional development. Students develop according to a structured plan and become more professional in their patient care. Students do not experience the clinical practice component of the programme as "work", but rather as an opportunity to develop their professional and personal skills while taking care of patients (Meyer and Van Niekerk, 2008:83).

When the academic, professional and personal outcomes are met, nursing students show evidence of decreased stress and self-confidence by means of calm, relaxed and assertive attitudes as well as high self-esteems (Pillay and Mtshali, 2008:50).

2.4 CONCLUSION

This chapter has presented an overview of the literature on clinical supervision and its three key dimensions namely the preconditions, the core and the outcomes of clinical supervision.

Clinical supervision affects students' opinions and interpretations of nursing and their enthusiasm towards it. During the course of their nursing studies, the foundations for opinions about the nursing profession are laid and effective supervision generates a positive impression of nursing. Clinical supervision reinforces professional growth and the development of self-evaluation and supports the need for lifelong learning. It is an effective way of recruiting personnel for the nursing profession because it adds to students' fulfillment and their desire to return to a specific ward or nursing field after completion of their training. Clinical supervision influences permanence and engagement of nurses in the nursing profession.

The purpose of the next chapter is to describe the research methodology applied by the researcher.

2.5 REFERENCES

ALLEN, B. 2008. Mind the gap. *British Journal of School Nursing*, 3(3):133-135.

ALTMANN, T.K. 2006. Preceptor selection, orientation and evaluation in baccalaureate nursing education. *International Journal of Nursing Education Scholarship,* 3(1):1-16.

ANDREWS, G.J., BRODIE, D.A., ANDREWS, J.P., HILLAN, E., THOMAS, B.G., WONG, J. AND RIXON, L. 2006**.** Professional roles and communications in clinical placements: a qualitative study of nursing students' perceptions and some models for practice. *International Journal of Nursing Studies,* 43(7):861-874.

ARJA, H., ERIKSSON, E., MERETOJA, R., SILLANPää, K. AND REKOLA, L. 2007. Nursing students in clinical practice - developing a model for clinical supervision. *Nurse Education in Practice*, 7(6):381-391.

AUSTRALIAN NURSING AND MIDWIFERY COUNCIL. 2005. Australian Nursing and Midwifery Council (ANMC). National competency standards for the registered nurse. Available from: http://www.anmc.org.au. [Accessed 17 October 2011].

BAXTER, P. 2007. The CCARE model of clinical supervision: bridging the theory-practice gap. *Nurse Education in Practice*, 7(2):103-111.

BESKINE, D. 2009. Mentoring students: establishing effective working relationships. *Nursing Standard*, 23(30):35-40.

BOURBONNAIS, F.F. AND KERR, E. 2006. Precepting a student in the final placement: reflections from nurses in a Canadian hospital*. Journal of Clinical Nursing*, 16(8):1543-1549.

BRAMMER, J. 2006. A phenomenographic study of registered nurses' understanding of their role in student learning – an Australian perspective. *International Journal of Nursing Studies,* 43(8):963-973.

BRAMMER, J.D. 2008. RN as gatekeeper: gatekeeper as monitoring and supervision. *Journal of Clinical Nursing*, 17(14):1868-1872.

BRYANT, L. 2010. Clinical supervision. *Practice nurse,* 39(12):36-41.

CANADIAN NURSES ASSOCIATION. 2009. Canadian Nurses Association. Registered nurse competencies. Available from: http://www.cna. [Accessed on 07 October 2011].

CARAYON, P. AND GURSES, A.P. 2008. Nursing workload and patient safety – a human factors engineering perspective. Available from: http://www.ncbi.nlm.nih.gov/books/NBK2657. [Accessed on 28 August 2011].

CARLSON, E., PILHAMMAR, E. AND WANN-HANSSON, C. 2010. Time to precept: supportive and limiting conditions for precepting nurses. *Journal of Advanced Nursing*, 66(2):432-441.

CASSIMJEE, R. AND BHENGU, M.P. 2006. Student nurses' perceptions of their contact time with stakeholders in their clinical instruction. *Curationis*, 29(4):47-53.

CHUR-HANSEN, A., AND MCLEAN, S. 2006. On being a supervisor: the importance of feedback and how to give it. *Australasian Psychiatry*, 14(1):67-71.

CLYNES, M.P. AND RAFTERY, S.E.C. 2008**.** Feedback: an essential element of student learning in clinical practice. *Nurse Education in Practice*, 8(6):405-411.

COOPER, J. 2009. Welcome to your work placement. *Nursing Standard*, 24(4):70-71.

COUGAR, J.P. 2010. Nurse educator definition. e How Contributor [online]. Available from: http://i.ehow.com/image/a06/3b/d4/nurse-educator-definition-1.1-800x800.jpg [Accessed 03 September 2010].

CROSS, W., MOORE, A. AND OCKERBY, S. 2010. Clinical supervision of general nurses in a busy medical ward of a teaching hospital. *Contemporary Nurse,* 35(2):245-253.

CROXON, L. AND MAGINNIS, C. 2009. Evaluation of clinical teaching models for nursing practice. *Nurse Education in Practice,* 9(4):236-243.

CURZON, L. 2004. Teaching in further education. 6th ed. London: Continuum.

DICKSON, C., WALKER, J. AND BOURGEOIS, S. 2006. Facilitating undergraduate nurses' clinical practicum: the lived experience of clinical facilitators. *Nurse Education Today*, 26(5):416-422.

DOLLING, C. AND ROGERS, M. 2011. Clinical supervision guidelines for nursing and allied helath professionals. NHS South Gloucestershire.

ELLIS, M.V. 2010. Bridging the science and practice of clinical supervision: some discoveries, some misconceptions. *The Clinical Supervisor*, 29(1):95-116.

EHRENBERG, A.C. AND HäGGBLOM, M. 2007. Problem-based learning in clinical nursing education: integrating theory and practice. *Nurse Education in Practice,* 7(2):67-74.

ETA, V.A.E., ATANGA, M.B.S., ATASHILI, J. AND D'CRUZ. 2011. Nurses and challenges faced as clinical educators: a survey of a group of nurses in Cameroon. *Pan African Medical Journal*, 8(28):1.

FITZGERALD, D.C. AND McALLEN, P.A. 2007. Precepting a student? Here are the job descriptions. *Home Health Care Management and Practice,* 19(6):464-469.

FOTHERINGHAM, D. 2009. Triangulation for the assessment of clinical nursing skills: A review of theory, use and methodology. *International Journal of Nursing Studies,* 47(3):386-391.

FRANKEL, A. 2008**.** Applying theory to practice through clinical supervision. *Nursing Times* [n.d.].

GOPEE, N. 2008a. Assessing student nurses' clinical skills: the ethical competence of mentors. *International Journal of Therapy and Rehabilitation*, 15(9):401-407.

GOPEE, N. 2008b. Mentoring and supervision in healthcare. Great Britain: SAGE.

HAIGH, C. 2008. Editorial: embracing the theory/practice gap. *Journal of Clinical Nursing*, 18(1):1-2.

HANBERG, A., BROWN, S.C., BILLINGS, D.M. AND KOWALSKI, K. 2006. Bridging the theory practice gap with evidence-based practice. *Journal of Continuing Education in Nursing*, 37(6):248-249.

HARDY, J. 2009. What to expect from your mentor. *Nursing Standard,* 24(4):70-71.

HARTIGAN-ROGERS, J.A., COBBETT, S.L., AMIRAULT, M.A. AND MUISE-DAVIS, E. 2007**.** Nursing graduates' perceptions of their undergraduate clinical placement. *International Journal of Nursing Education Scholarship*, 4(1):1-12.

HEATHFIELD S.M. 2012. What are human resources? [Online]. Available form: http://humanresources.about.com/od/glossaryh/f/whathr.htm. [Accessed 26 November 2012].

HENDERSON, A. 2011. Leadership in clinical education - embedding learning in everyday practice. *Nursing Education Today*, 31(1):4-5.

HENDERSON, A., FOX, R. AND MALKO-NYHAN, K. 2006. An evaluation of preceptors' perceptions of educational preparation and organizational support for their role. *Journal of Continuing Education in Nursing*, 37(3):130-136.

HENDERSON, A. AND TYLER, S. 2011. Facilitating learning in clinical practice: evaluation of a trial of a supervisor of clinical education role. *Nurse Education in Practice*, 11(5):288-292.

HENDERSON, A., TWENTYMAN, M., EATON, E., CREEDY, D., STAPLETON, P. AND LLOYD, B. 2009. Creating supportive clinical learning environments: an intervention study. *Journal of Clinical Nursing*, 19(2):177-182.

HUNTER, K. 2011. Nursing skills – the importance of practical experience [Online]. Liverpool, UK. Available from: http://ezinearticles.com/?NursingExperience&id=3797890 [Accessed 08 April 2011].

JERVIS, A. AND TILKI, M. 2011. Why are nurse mentors failing to fail student nurses who do not meet clinical performance standards? *British Journal of Nursing,* 20(9):582-587.

JONES, A. 2007. Putting practice into teaching: an exploratory study of nursing undergraduates' interpersonal skills and the effects of using empirical data as a teaching and learning resource. *Journal of Clinical Nursing*, 16(12):2297-2307.

JIANG, R., CHOU, C. AND TSAI, P. 2012. Preceptor-guided clinical practica and the learning experiences of nursing students. *The Journal of Nursing Research,* 20(2):152-157.

KELLY, C. 2007. Student's perceptions of effective clinical teaching revisited. *Nurse Education Today*, 27(8):885-892.

KEMPER, N.J. 2007. Win-win strategies help relieve preceptor burden. *Nursing Management*, 38(2):10-12.

KILMINSTER, S., COTTRELL, D., GRANT, J. AND JOLLY, B. 2007. Effective educational and clinical supervision. *Medical Teacher*, 29(1):2-19.

KING, L.M., JACKSON, M.T., GALLAGHER, A., WAINWRIGHT, P AND LINDSAY, J. 2009. Towards a model of the expert practice educator – interpreting multi-professional perspectives in the literature. *Learning in Health and Social Care,* 8(2):135-144.

KRAUTSCHIED, L. 2008. Improving communication among healthcare providers: preparing student nurses for practice. *International Journal of Nursing Education Scholarship,* 5(1):1-13.

LAFAUCI, F.F. 2009. Second year associate degree nursing students and nursing faculty attitudes towards clinical educational experiences. Dowling College. (Dissertation) 155.

LENERS, D., SITZMAN, K. AND HESSLER, K.L. 2006. Perceptions of nursing student clinical placement experiences. *International Journal of Nursing Education Scholarship*, 3(1):2.

LEVETT-JONES, T., LATHLEAN, J. HIGGINS, I. AND MCMILLAN, M. 2008. The duration of clinical placements: a key influence on nursing students' experience of belongingness. *Australian Journal of Advanced Nursing*, 26(2):8-16.

LILLIBRIDGE, J. 2006**.** Using clinical nurses as preceptors to teach leadership and management to senior nursing students: a qualitative descriptive study. *Nurse Education in Practice*, 7(1):44-52.

LINSLEY, P., KANE, R., McKINNON, J., SPENCER, R. SIMPSON, T. 2008. Preparing for the future: nurse education and workforce development. *Quality in Primary Care*, 16(3):171-176.

LUHANGA, F., YONGE, O. AND MYRICK, F. 2008. Precepting an unsafe student: the role of the faculty. *Nurse Education Today*, 28(1):227-231.

LYNCH, L., HANCOX, K., HAPPELL, B. AND PARKER, J. 2008. Clinical supervison for nurses. Singapore: Wiley.

MABUDA, B.T., POTGIETER, E. AND ALBERTS, U.U. 2008. Student nurses' experiences during clinical practice in the Limpopo Province. *Curationis*, 31(1):19-27.

MACKENZIE, K.M. 2009. Who should teach clinical skills to nursing students? *British Journal of Nursing*, 18(7):239-240.

MAGINNIS, C. AND CROXON, L. 2010. Transfer of learning to the nursing clinical practice setting [Online]. Available from: http://www.rrh.org.au [Accessed 20 July 2011].

MANNIX, J., WILKES, L. AND LUCK. 2009. Key stakeholders in clinical learning and teaching in Bachelor of Nursing programs: A discussion paper. *Contemporary nurse*, 32(1)59-68.

MCGOWAN, B. 2006. Who do they think they are? Undergraduate perceptions of the definition of supernumerary status and how it works in practice. *Journal of Clinical Nursing*, 15(9):1099-1105.

MCKIMM, J. 2009. Giving effective feedback. *British Journal of Hospital Medicine*, 70(3):158-16.

MCNAMARA, M.S. 2007. Illuminating the essential elements role of the clinical placement coordinator: a phenomenological inquiry. *Journal of Clinical Nursing*, 16(8):1516-1524.

MEYER, S AND VAN NIEKERK, S. 2008. Nurse educator in practice. Cape Town: Juta & Company.

MILLER, K., RILEY, W. AND DAVIS, S. 2009. Identifying key nursing and team behaviours to achieve highly reliability. *Journal of Nursing Management*, 17(2):245-255.

MOSCARITOLO, L.M. 2009. Interventional strategies to decrease nursing student anxiety in the clinical learning environment. *Journal of Nursing Education*, 48(1):17-23.

NEWTON, J.M., BILLET, S. AND OCKERBY, C. M. 2009. Journeying through clinical placements – an examination of six student cases. *Nurse Education Today*, 29(6):630-634.

PAPA, J. 2011. What is effective communication in nursing? [Online]. Available from: http://www.ehow.com/print/about5377899effectivecommunicationnursinghtml [Accessed 25 September 2011].

PETER, Z.P. 2008. An evaluation of clinical facilitation in the nursing college of the Eastern Cape Province. Stellenbosch. (Dissertation – MSc)1.

PILLAY, P. AND MTSHALI, N.G. 2008. Clinical supervision and support for bridging programme students in the greater Durban area. *Curationis,* 31(4):46-56.

POPE, B.B., RODZEN, L. AND SPROSS, G. 2008. Raising the SBAR: How better communication improves patient outcomes. *Nursing*, 38(3):41-43.

QUINN, F.M. AND HUGHES, S.J. 2007. Quinn's principles and practice of nurse education. 5th ed. United Kingdom: Nelson Thornes.

SAYERS, J. AND DAVIDSON, P. 2009. Nurse educators – an endangered species? *Australian Nursing Journal,* 16(9):23**.**

SEDGWICK, M.G. AND YOUNG, O. 2008. Were it, were a team, were family means a sense of belonging. *The international Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy,* 8(3):1-12.

SCHERER, Z.A. AND SCHERER, E.A. 2007. Reflections on nursing teaching in the post-modernity era and the metaphor of a theory-practice gap. *Revista Latino-Americana De Enfermagem,* 15(3):498-501.

SIMS, J. 2009. We have a duty to mentor students on placement. *Nursing Standard*, 23(31):33.

SKINGLEY, A., ARNOTT, J., GREAVES, J. AND NABB, J. 2007. Supporting practice teachers to identify failing students. *Br J Community Nurse,* 12(1):28-32.

SOUTH-AFRICA. Department of Health. 2012. Strategic Plan for Nursing Education, Training and Practice 2012/2013-2016/17. Pretoria: Government Printers.

SOUTH AFRICAN NURSING COUNCIL. 1985. *Regulation relating to the approval of and the minimum requirements for the education and training of a nurse (General, Psychiatric and Community) and Midwife leading to registration.* Regulation R425 in terms of the Nursing Act, 2005, Act no 33 as amended. Pretoria: Government Printers.

SOUTH AFRICAN NURSING COUNCIL. 1993. *Regulation relating to the course leading to enrolment as a nurse.* Regulation R2175 in terms of the Nursing Act, 2005, Act no 33 as amended. Pretoria: Government Printers.

SOUTH AFRICAN NURSING COUNCIL. 2006. *Nursing Act No. 33 of 2005.* Government Gazette, 28883:491. Government Printers.

STUART, C.C. 2004. Assessment, supervision and support in clinical practice. China: Churchill Livingstone.

STUDYMODE. 2008. Nursing: essential knowledge, skills and attitudes. [Online]. Available from http://www.studymode.com/essay/Nursing-Essential-Knowledge-Skills-Attitude-161696.html [Accessed 25 September 2011].

TAYLOR, C. 2009. Mutually supportive. *Nursing Standard*, 24(1):61.

TEEPA, K. 2011. Making the most of a clinical placement. *Kai Tiaki Nursing New Zealand*, 17(3):35.

VALLANT, S. AND NEVILLE, S. 2006. The relationship between student nurse and nurse clinician: impact on student learning. *Nursing Praxis in New Zealand*, 22(3):23-33.

WALDOCK, J. 2010. Facilitating student learning in clinical practice. *Kai Tiaki Nursing New Zealand*, 16(1):14-16.

WARREN, D. 2010. Facilitating pre-registration nurse learning: a mentor approach. *British Journal of Nursing*, 19(21):1364-1367.

WILKES, Z. 2006. The student-mentor relationship: a review of the literature. *Nursing Standard,* 20(37):42-47.

WILLIAMS, L. AND IRVINE, F. 2009. How can the clinical supervisor role be facilitated in nursing: a phenomenological exploration. *Journal of Nursing Management,* 17(4):474-483.

WILSON, J. 2008. Bridging the theory practice gap. *Australian Nursing Journal*, 16(4):25.

ZILEMBO, M. AND MONTEROSSO, L. 2008. Nursing students' perceptions of desirable leadership qualities in nurse preceptors: a descriptive survey. *Contemporary Nurse*, 27(2):194-206.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research methodology refers to the individual steps, advanced procedures and strategies used by the researcher when collecting and analysing data during the research process (Babbie and Mouton, 2009:75; Polit and Beck, 2008:328). The purpose of applying the particular research methodology is to obtain possible answers for the identified problem (Brink, Van der Walt and Van Rensburg, 2008:53).

In the previous chapter, the literature published from having conducted various research studies on clinical supervision, was reviewed. In this chapter the researcher presents a general overview of the design of the study, the development of the research idea, the research techniques used, population and sampling, the pilot study, data collection and the analysis plan selected and applied by the researcher. Additional to these aspects important criterion for scientific research such as reliability, validity and ethical considerations are described.

3.2 AIM OF THE STUDY

The aim of the proposed study is to describe the views of the different categories of nurses on clinical supervision in the SAMHS.

3.3 OBJECTIVES

The research objectives of the study are:

- to describe the views of nurse educators, professional nurses, nursing students and pupil enrolled nurses with regard to clinical supervision in the SAMHS and

- to formulate recommendations to improve clinical supervision based on the results of the research

3.4 RESEARCH DESIGN

In comparison with research methodology, which refers to the method(s) used by researchers to collect and analyse data (Babbie and Mouton, 2009:75; Polit and Beck, 2008:328), the research design is a set of logical steps taken by the researcher to address the research question (Brink et al., 2008:92; Polit and Beck, 2008:16). This serves as the backbone of the research study and determines the structure for the research methodology as well as the design decisions enabling the researcher to achieve the intended goal (Botma, Greeff, Molaudzi and Wright, 2010:108; Brink et al., 2008:92; Burns and Grove, 2009:41). A research design allows the researcher maximum control over aspects that could affect the validity of the findings and increases the possibility that the study results are true reflections of reality (Brink et al., 2008:92; Burns and Grove, 2009:218).

A quantitative, non-experimental descriptive research design was chosen by the researcher in order to achieve the objectives of the study. This commonly used design will be described in detail.

3.4.1 Quantitative research design

The quantitative researcher is of the opinion that the most suitable way of measuring the properties of phenomena are through quantitative measurement, e.g. by allocating numbers to the identified qualities of things (Babbie and Mouton, 2009:49). Quantitative designs are divided into experimental and non-experimental designs (Brink et al., 2008:92; Polit and Beck, 2008:63). Due to the fact that the researcher collected data without any manipulation of any variables, the study can be classified as non-experimental. The study was conducted in an uncontrolled setting and phenomena were observed as they occurred. The main aim of non-experimental research is to

describe phenomena, and examine and portray the relationship between variables (Brink et al., 2008:102). Researchers use interviews and questionnaires to gather numeric information directly from respondents and to analyse it afterwards by means of statistical procedures (Polit and Beck, 2008:16). Contrary to this, experimental designs focus on the testing of hypotheses and the establishing of causality. This differs from non-experimental designs in such a way that the researcher has the ability to control the action of the dependent variable(s) and can therefore observe and measure the action or outcome on the dependent variable(s) (Brink et al., 2008:92).

One of the advantages of quantitative studies is that they allow the researcher greater objectivity in research situations and that the researcher has no power to influence them (Shuttleworth, 2008:Online). Another reason for choosing quantitative research might be because it completely eradicates bias and inspires researchers to keep a short distance from the participating subjects. It filters out all external factors and if well designed, provides unbiased and real results (Daniel, 2011:Online). Throughout the study the researcher has to take into account all aspects that could weaken the validity and reliability of the study and pro-actively needs to plan in order to decrease their effect (Botma et al., 2010:174). During the course of the present study's data collection, unforeseen events, which influenced the number of respondents, occurred but the researcher still managed to obtain an adequate amount of complete questionnaires. For this reason the reliability of the study's results remained intact.

3.4.2 Descriptive designs

A descriptive design is a non-experimental, quantitative design that allows a researcher to observe and describe the variables as they naturally occur with the intention to answer the research question (Botma et al., 2010:110; Brink et al., 2008:102; Polit and Beck, 2008:274). Descriptive designs permit the researcher to identify problem areas within a particular field of the nursing practice, to warrant current clinical practice, or might be used to develop theories or to establish what others are doing in similar situations (Botma et al., 2010:110; Burns and Grove, 2009:237). The specific design of

the present study did not make room for the manipulation of the research variables and there was no attempt to establish a cause-effect relationship between the variables (Botma et al., 2010:110; Brink et al., 2008:102). Through descriptive designs information is generated from a representative sample of the population and makes use of structured observation, questionnaires and interviews or survey studies during the data collection phase (Brink et al., 2008:103).

Whilst conducting the research the researcher intended to describe the views of nurse educators, professional nurses, nursing students and pupil enrolled nurses with regard to clinical supervision in the SAMHS. The researcher did not attempt to determine the cause or the effect, and did not try to manipulate any variables in order to get answers to the research problem. For this reason the quantitative descriptive design was deemed the most suitable research design for the study at hand.

3.5 FLOW OF STEPS IN THE QUANTITATIVE DESCRIPTIVE RESEARCH STUDY

The flow of steps is outlined in Figure 3.1. The study was conducted over a period of two years. With the exception of the literature review and the formulation of a research problem, each aspect is discussed in detail in the remaining sections of this chapter.

3.6 RESEARCH TECHNIQUES

The data gathering methods that health professionals often use in quantitative research are self-report, observation and physiological measurements (Botma et al., 2010:133; Brink et al., 2008:143) as well as the less frequent use of existing data and critical incidents (Botma et al., 2010:133). Structured questionnaires and scales that can be classified under self-report instruments were found to be relevant for use by the researcher in the quantitative descriptive research study, seeing that the research population was too large to observe directly (Burns and Grove, 2009:44). Guidelines for questionnaire development and the advantages and disadvantages thereof, as well as use of the Likert scale are discussed.

3.6.1 Guidelines for questionnaire development

In collaboration with the study leader, the researcher in developed the questionnaires used during the research study. Special attention was given to the essential content that had to be covered and the way that questions were formulated (Brink et al., 2008:148; Burns and Grove, 2009:406).

Specific research issues that required investigation were listed (Brink et al., 2008:148). The researcher had to be conversant with the relevant literature (Brink et al., 2008:148; Burns and Grove, 2009:406) and had to identify, from the relevant literature, the information that was needed to eventually address the research question, the aim and the objectives. Questions were then formulated and constructed and each one was tested for precision of expression, relevance, objectivity, suitability and the probability of reception and return (Brink et al., 2008:148). The aspects that were considered included open versus closed-ended questions, phrasing of the questions, the length of the questionnaire, question arrangement and the overall appearance of each questionnaire (Brink et al., 2008:150).

Unstructured open-ended questions as well as structured closed-ended questions were included in the questionnaires. Open-ended questions permit the respondent to answer in any way after having given it some thought, while closed-ended questions necessitate respondents to choose from a set of alternatives (Babbie and Mouton, 2009:233; Brink et al., 2008:148; Burns and Grove, 2009:406). One of the disadvantages of closed-ended questions is that they restrict the answers to the options provided. Open-ended questions are not grounded on predetermined answers and were therefore deemed appropriate for the descriptive explanatory study. These questions allow richer, more diverse data to be collected. The coding and the analysis thereof are more difficult than those of closed-ended questions (Botma et al., 2010:134; Brink et al., 2008:148). The inclusion of open-ended questions in the questionnaires was limited. In order to prevent misinterpretation of these questions, the researcher took the responsibility to code the data and did not involve any other person in the process.

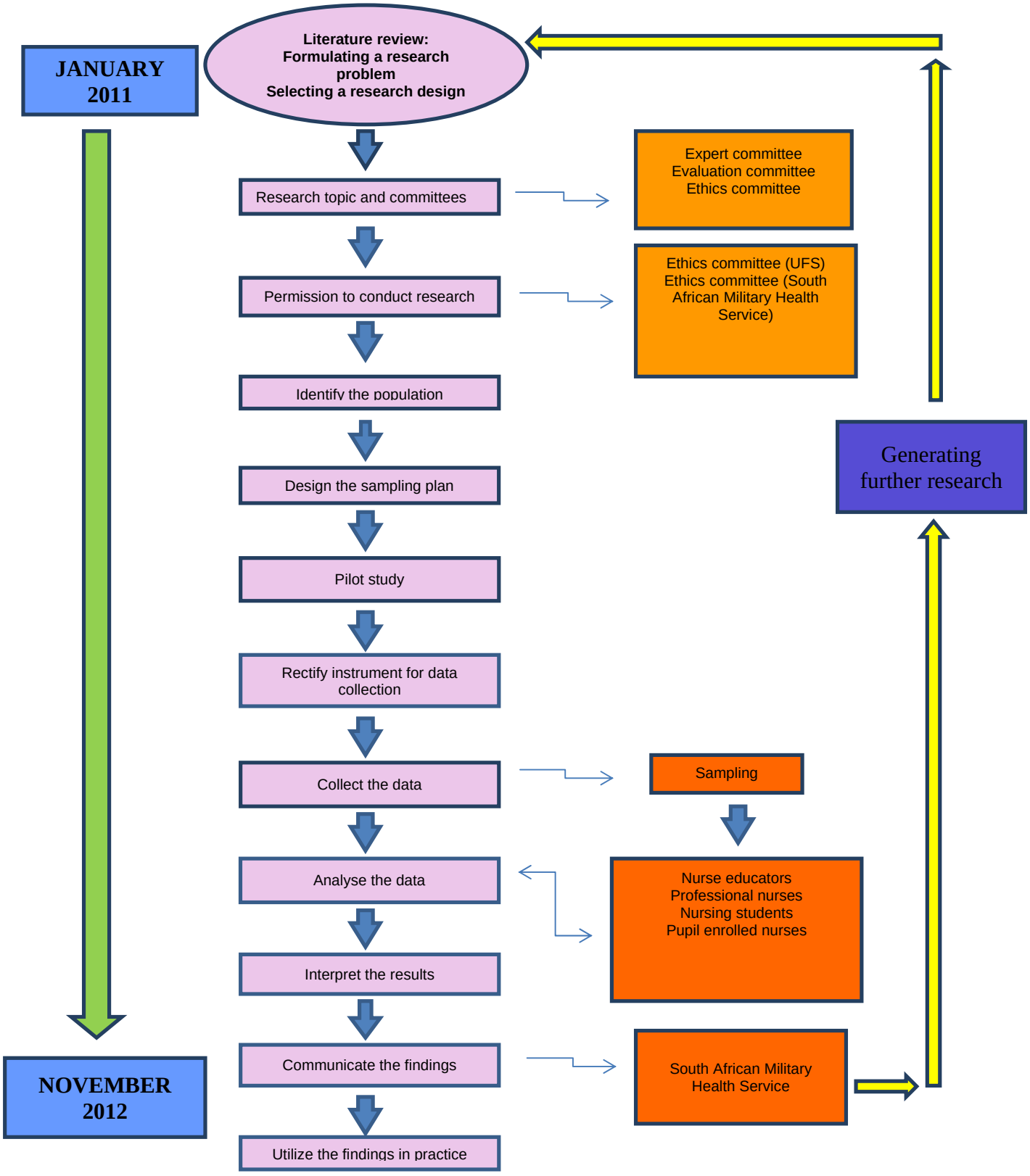

Figure 3.1: Flow of steps in the research study.

The length of a questionnaire is also an important aspect to consider (Brink et al., 2008:150; Burns and Grove, 2009:406). The main purpose of a questionnaire is that it should only obtain the necessary information from the respondent. Should it be too long it may discourage a response and bore the respondent (Brink et al., 2008:150). According to Brink, Van der Walt and Van Rensburg (2008:151), questionnaires should take no more than 20 to 25 minutes to complete. The questionnaires were compiled in such a way that it did not take a respondent more than 30 minutes to complete a questionnaire. A pilot study was conducted to pre-test the questionnaires since it serves as a trial run for establishing whether the questionnaires are clearly worded and free from major bias, and whether they are suitable for the type of information needed (Brink et al., 2008:151; Burns and Grove, 2009:409).

Attention was given to the neatness of the questionnaires and their grammatical correctness. Questionnaires were presented without any typing and spelling errors. Respondents were provided with clear instructions on the cover page of the questionnaires on how to complete these and to encourage full completion (Brink et al., 2008:92). The questionnaires were distributed by the researcher. A covering letter accompanying the questionnaires informed respondents of the purpose of the study, provided the researcher's name and indicated the estimated time required to complete the questionnaires (Burns and Grove, 2009:409).

3.6.1.1 Advantages and disadvantages of questionnaires

When questionnaires are used in the gathering of data a number of advantages can be identified. They allow the researcher to gather a considerable amount of data in a short space of time. If validity and reliability of the questionnaires has been ensured beforehand, quality data can be collected with confidence (Botma et al., 2010:135; Brink et al., 2008:147). The proposed anonymity may increase the degree of honesty with which respondents answer the questions (Brink et al., 2008:147; Botma et al., 2010:135; Polit and Beck, 2008:424).

The disadvantages using questionnaires must be taken into account before a final decision is made with regard to its suitability as a data gathering instrument. A low response rate, questions that are left unanswered, answers subjected to social interest, bias and inconsistent responses are some of the disadvantages of using questionnaires for data collection. There may also be the possibility that the researcher is not in a position to clarify a misunderstanding during completion of a questionnaire and the response that was given at the time, might have resulted from an incorrect perception. The literacy level of the respondents needs to be taken into account seeing that this may subject the data gathered to selection bias (Botma et al., 2010:135; Brink et al., 2008:147).

3.6.1.2 Scales

Scales can be classified under self-report data-collection instruments and measure phenomena more accurately than questionnaires. These measures determine respondents' attitudes and opinions on a continuum. There are different types of scales but the Likert scale is well known in nursing research and will therefore be discussed in detail (Brink et al., 2008:153; Botma et al., 2010:138; Burns and Grove, 2009:410).

3.6.1.3 Likert scales

The Likert scale includes a number of declarative statements followed by response categories after each statement (Brink et al., 2008:153; Botma et al., 2010:138; Burns and Grove, 2009:410). Respondents have to indicate the degree to which they agree or disagree with the opinion expressed by the statement (Polit and Beck, 2008:419). The four response categories that the researcher included in the Likert scale were "strongly agree; agree; disagree; and strongly disagree". A numerical value was assigned to each response category, for e.g. 1-4 (Botma et al., 2010:138; Brink et al., 2008:153; Burns and Grove, 2009:410). A score of 1 was allocated to "strongly agree" and a score of 4 to "strongly disagree" (Botma et al., 2010:138).

3.6.1.4 The structure of the questionnaires compiled for the study

The conceptual framework of the proposed research study determines which questions are to be answered by the research (De Vos, Strydom, Fouché and Delport, 2011:35) and thus this was taken into consideration during the compilation of the questionnaires. The three essential dimensions for clinical supervision (i.e. prerequisites, core and outcomes) were addressed.

The questionnaire for nurse educators and professional nurses consisted of five sections. Section A included six closed-ended questions on demographic data. In the second section, (B), the researcher collected data through four open- and two closed-ended questions on clinical supervision by nurse educators and professional nurses with regard to nursing students. Section C included data on clinical supervision by nurse educators and professional nurses with regard to pupil enrolled nurses and four open- and two closed-ended questions were used in the collection of data. Data on the roles and responsibilities of nurse educators in the clinical setting was collected in section D by means of the Likert scale. One open-ended question was used to collect data on the improvement of clinical supervision. In the last section, (E), the researcher collected data on the responsibilities of professional nurses in the clinical setting by means of the Likert scale. The researcher used one open-ended question for the collection of data on professional nurse's recommendations for improvement of clinical supervision.

The questionnaire for nursing students and pupil enrolled nurses consisted of three sections in which information was categorised. Section A included six closed-ended questions on demographic data. In section B, the researcher used four open- and two closed-ended questions to gather data on the clinical supervision of nursing students and pupil enrolled nurses. The researcher collected data in section C on the roles and responsibilities of nurse educators and professional nurses in clinical supervision by means of the Likert scale. The last question in section C is an open-ended question that was used to collect data on recommendations to improve clinical supervision.

3.7 POPULATION

The research population refers to the total number of respondents sharing specific features, that can possibly be included in the study (Brink et al., 2008:123; Burns and Grove, 2009:42; Polit and Beck, 2008:761). Sometimes the concept target population is used and includes all individuals that meet the sampling criteria. The group that is targeted might not all be available and therefore some of the individuals may be excluded from the study. When conducting a research study the researcher seldom has access to the entire population. The respondents that are available or accessible as participants of the study are termed the accessible population (Botma et al., 2010:124; Brink et al., 2008:123).

For the purpose of this study all categories of nursing personnel in the SAMHS were identified as the target population. The target population for the study comprised of first- and second-year pupil enrolled nurses (leading to enrolment as a nurse) and nurse educators of the nursing colleges in Cape Town and Bloemfontein respectively. Professional nurses of both 2 and 3 Military Hospitals were included. First-, second- and fourth-year nursing students (leading to registration as a professional nurse) as well as the nurse educators of the nursing college in Thaba Tshwane and professional nurses of 1 Military Hospital, who were directly involved in the basic nursing education and training programme, were included in the study. Due to the fact that the latter nursing college did not have an intake of students two years before, there was no third-year nursing student group and therefore this not included in the research study.

3.8 SAMPLING

A sample is a fraction of a population selected by the researcher from the target population to participate in a research study (Bless, Higson-Smith and Kagee, 2006: 97; Burns and Grove, 2009:42; Polit and Beck, 2008:765). With sampling the main aim is to obtain information about a phenomenon that represents the population of interest (Brink et al., 2008:124). For the purpose of the study the researcher collected data from the

sample. The sample consisted of elements selected through the random sampling technique. This technique was chosen to exclude bias and to ensure that all nurse educators, professional nurses, nursing students and pupil enrolled nurses were granted equal opportunity during the selection process (Brink et al., 2008:126). There are several techniques for conducting random sampling. The most commonly used method is the lottery technique. A symbol for each element of the population is placed in a container, mixed well and then the "lucky numbers" are drawn that constitute the sample. This symbol can be either names of respondents, written on identical pieces of paper, or a number assigned to each respondent. The sample size needs to be determined beforehand in order to know how many symbols to draw (Bless et al., 2008:101).

In order to ensure a representative sample from the target population, the lottery technique was used in the research study. Name lists of all the different nursing categories were collected from the various human resource departments. The names of all the respondents, according to their categories, were written on identical pieces of paper, placed in a container and mixed together after which the "lucky respondents" were drawn. The sample size was established beforehand.

A convenient sample for the research study was drawn from three nursing colleges: Thaba Tshwane, Cape Town and Bloemfontein. The aim was to include 60% (n=26) of the total population of nurse educators at Thaba Tshwane, but the researcher only managed to include 23% (n=10) of the population size (Table 1.3). At the Bloemfontein and Cape Town nursing colleges 60% (n=4) of the total population size of nurse educators was included.

The professional nurses employed at the three military hospitals came to a total of 636 (Table 1.4). The intention was to include 60% (n=283) of the total professional nurse population at 1 Military Hospital, but the respondents who voluntarily completed questionnaires constituted 10% (n=46) of the population size. At 3 Military Hospital in Bloemfontein the researcher planned to include 60% (n=34) of the total population size

but managed to include 53% (n=30). Only 39% (n=42) of the professional nurse population voluntarily agreed to complete questionnaires at 2 Military Hospital in Cape Town, while the aim was set at 60% (n=65). A point worth noting is that the target population size for nurse educators and professional nurses could not be reached in some instances and can thus be regarded as a limitation of the research study.

Thaba Tshwane nursing college had a total number of 214 (2010) first-, second- and fourth-year nursing students. Due to the fact that the main campus did not have an intake of new students two years before, there was no third-year group when data was collected (Table1.2). The first-year students who voluntarily completed questionnaires added up to 61 (n=101), while a total number of 17 (n=69) of the second-year nursing students took part in the research study. The researcher managed to include 26 (n=44) of the fourth-year nursing students.

From a total population of 74 pupil enrolled nurses at the Bloemfontein and Cape Town nursing colleges, 44 (n=74) of the respondents were included (Table 1.1). A total number of 10 first-year and 12 second-year pupil enrolled nurses were included from the Bloemfontein nursing college. The pupil enrolled nurse sample from the Cape Town nursing college, constituted 12 first-year and 10 second-year students.

3.9 PILOT STUDY

A pilot study, sometimes referred to as a preliminary study, needs to be conducted to test the practicalities of the research study (Brink et al., 2008:166). This is a small-scale version of the larger study (Botma et al., 2010:275; Brink et al., 2008:166; Burns and Grove, 2009:44). Through conducting the pilot study an opportunity is given to establish whether the potential respondents will understand what needs to be done. The researcher can get clarity on different aspects such as whether the instructions or wording are clear, if vagueness can be detected in the data-collection instruments. or if any possible humiliating or culturally insensitive issues are present (Botma et al.,

2010:275; Brink et al., 2008:166). Afterwards data are coded to determine any potential coding problems (Botma et al., 2010:275).

The same population and data collection technique was used in the larger study (Burns and Grove, 2009:44). Data collected during the pilot study was included to support the results of the larger study because not obscurities needing rectification were found in the questionnaires. The time needed for completion of a questionnaire was pre-tested during the pilot study to ensure that a respondent would not use more time than was indicated. The researcher involved the biostatistician after conducting of the pilot study and permission was granted to continue with the full-scale study. There was no need to train additional fieldworkers because data collection for the study was performed by the researcher.

3.10 DATA COLLECTION

Data collection is regarded as one of the most decisive phases in the research process and requires thorough planning in order to collect accurate data (Burns and Grove, 2009:249). The data collection process of the research study may be depicted by means of the flow diagram in Figure 3.2. The planning and carrying out of the data collection process are discussed thereafter.

Data for the study was collected within four weeks of which the first week took place at 3 Military Hospital. After written permission was granted by the chief executive officer of this hospital and the vice-principal of the nursing college in Bloemfontein, data collection was initiated. The respondents selected by random sampling were provided with a covering letter before completion of the questionnaires. Questionnaires were handed to respondents in a private environment away from fellow colleagues and patients and completion took up 30 minutes of their time. Thirty (n=34) of the professional nurses (i.e. 53%), 4 (n=4) of the nurse educators (i.e. 60%) and a total number of 10 first- and 12 second-year pupil enrolled nurses (i.e. 60%) voluntarily participated in data collection.

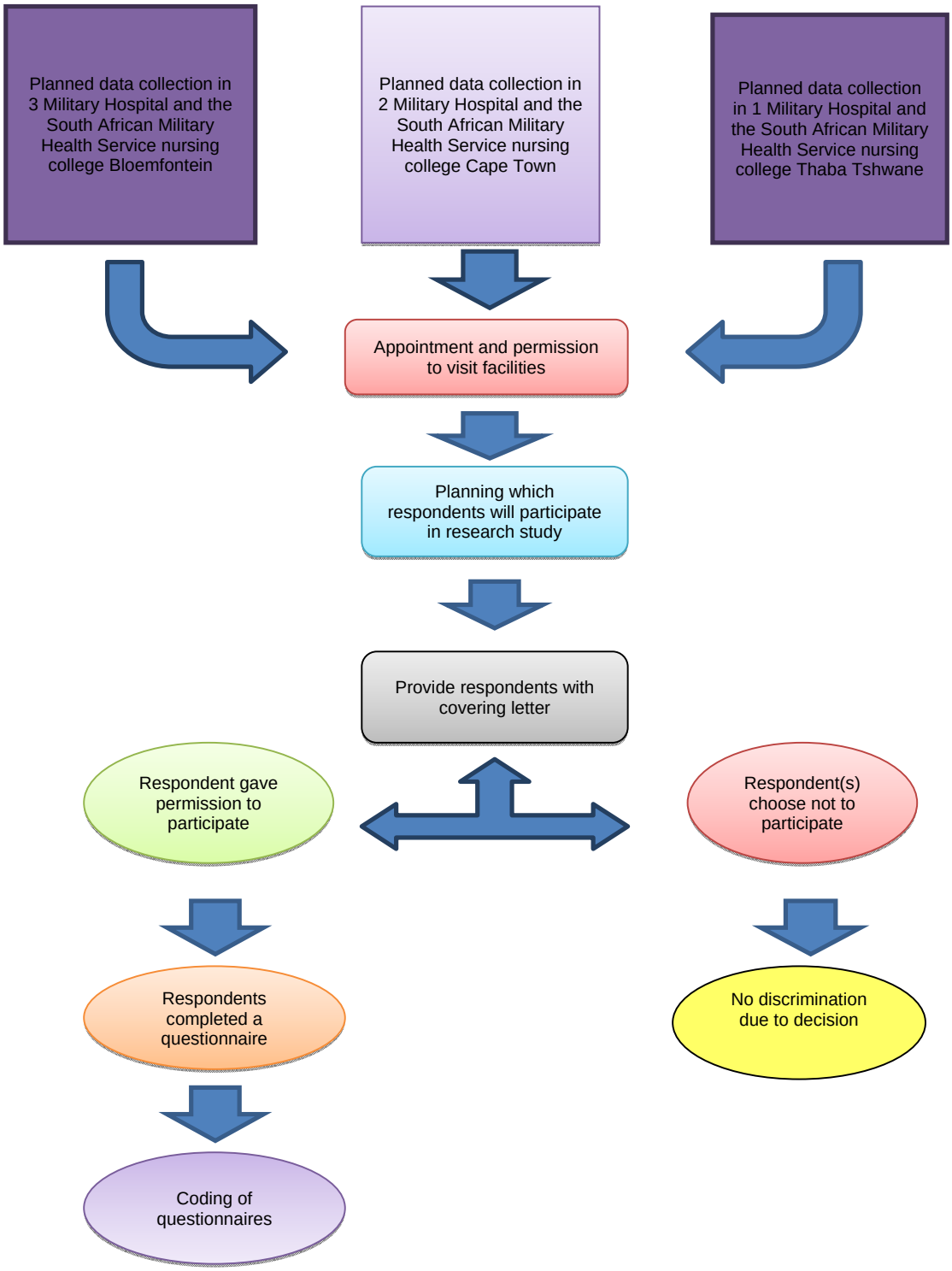

Figure 3.2: Flow diagram of data collection process

The collection of data at 2 Military Hospital and the nursing college in Cape Town took place during the second week. Primary data collected by the researcher is most appropriate to the aims of the research, since the data gathered is directed towards answering the questions raised precisely (Bless et al., 2006:112). Written permission from the chief executive officer of the hospital and the vice-principal of the nursing college in Cape Town was obtained. Before arrival management was telephonically informed about when the data collection process was to commence. Because the researcher collected the data, funds needed to be available for accommodation and travelling costs.

Respondents were selected through the random sampling technique and a total number of 42 (n=65) professional nurses, 4 (n=4) of the nurse educators and 10 (n=10) first-year and 10 (n=12) second-year students participated voluntarily and completed self-administered questionnaires. All respondents were given the covering letter before questionnaires were handed to them for completion and the same procedure was followed.

The last two weeks were spent at 1 Military Hospital and the nursing college in Thaba Tshwane. Written permission was obtained from the chief executive officer of the hospital and the principal of the nursing college. Management was again telephonically informed of the period for which data collection was planned. Accommodation and travelling costs were paid by the Department of Defense. The random sampling technique was used and a total number of 46 (n=283) professional nurses, 10 (n=26) nurse educators, 61 (n=61) first-year nursing students, 17 (n=41) second-year nursing students and 26 (n=26) fourth-year nursing students took part in the research study voluntarily. The main campus did not have an intake of new students in 2009 and therefore there was no third-year group the time of data collection (Table1.2).

In some instances difficulty was experienced including the number of respondents, initially planned. This was due to the following reasons:

- deployment to foreign countries
- Attendance of military courses
- Attendance of courses for professional development
- working night duty
- Working shifts
- vacation leave
- sick leave

All respondents thanked for their inputs and time after completion of the questionnaire. Subsequent to the four weeks scheduled for the data collection process, the researcher started to prepare the questionnaires for data-analysis.

3.11 VALIDITY AND RELIABILITY

The quality of research depends largely on the quality of the measuring instruments (Houser, 2008:297). For quantitative research the measuring instruments have to measure up to important criteria such as validity and reliability. These two concepts are closely related and consideration has to be given to both during the selection of an appropriate instrument (Brink et al., 2008:165). The reason for this is that a measuring instrument can be valid but not reliable, and vice versa (Bless et al., 2006:156; Brink et al., 2008:165; Burns and Grove, 2009:380). Therefore, validity and reliability were considered important criteria during the compilation of the questionnaires in order to guarantee a successful research study. The manner in which the researcher tried to measure up to the criteria will be discussed in more detail below.

3.11.1 Validity

Validity of the measuring instrument influences the degree to which it reflects the abstract construct being examined (Babbie and Mouton, 2009:122; Burns and Grove, 2009:380). Research requires the researcher to think through threats to validity and determine the severity of these threats and how these may affect the integrity of the

findings (Burns and Grove, 2009:221). Although the final validity of a measure can never be established, we may agree to its relative validity on the basis of face validity, criterion validity, content validity and construct validity (Babbie and Mouton, 2009:648). Various methods can be used to enhance the validity of data-collection instruments. Face- and content validity were used by the researcher and will subsequently be discussed.

3.11.1.1 Face validity

Face validity is based on the judgement made by experts in the field. The data collection instruments ought to be tailor-made to the needs of the elements for which it is planned (Bless et al., 2006:160). Face validity cannot be quantified nor tested, but is enhanced when a panel of experts scrutinise the data collection instruments beforehand (Maree, 2007:217). The data collection instruments were laid before the Expert- and Evaluation Committees respectively. The panel of experts was represented by the study leader, the portfolio head (research) of the UFS's School of Nursing, the UFS's biostatistician (Faculty of Health Sciences), a representative from this faculty and a representative from the academic staff, of the School of Nursing.

Valuable inputs from the experts contributed to the development of a self-administered questionnaire that included appropriate questions for respondents. The portfolio head (research) of the School of Nursing enquired about the necessity of two different questionnaires and suggested that if possible the questionnaires should be joined. A clear explanation was given on the reason for the two separate questionnaires and a decision was taken to maintain the status quo. Technical aspects to facilitate easy completion of the questionnaires were suggested by the research division of the faculty's Ethics Committee. The top paragraph of the cover page on the information leaflet had to be removed and added to the first page of each of the questionnaires. The heading on top of the information leaflet "Consent to participate" had to be changed to "Information document for participants." The signature block where respondents had to sign consent was removed to ensure their anonymity.

3.11.1.2 Content validity

A data collection instrument has high content validity when it measures all the various components of the variables in question (Bless et al., 2006:157; Brink et al., 2008:160). As with face validity the researcher constructed the questionnaires base on a literature review, and made use of experts with experience in the research area to evaluate the content validity of the data collection instruments (Bless et al., 2006:157). The experts who evaluated the questionnaires have already been listed. Content validity is a primary consideration in the development of questionnaires (Bless et al., 2006:160).

The aim of the questionnaires was to determine the views of nurses in different nursing categories on clinical supervision in the SAMHS.

To ensure that all aspects were measured correctly, the following components were included in the questionnaires and held up for scrutiny:

- demographic data of the respondents
- time spent on clinical supervision
- the nursing category responsible for clinical supervision
- suggestions with regard to clinical supervision
- roles and responsibilities of different nursing categories

The second major concern during the data collection process is the reliability of the research instrument (Bless et al., 2006:160, Brink et al., 2008:163). The manner in which the researcher ensured reliability will be discussed.

3.11.1.3 Reliability

Reliability refers to the extent to which the particular instrument can produce equivalent results if used frequently over time on the same person, or if used by more than one researcher (Bless et al., 2006:150; Brink et al., 2008:163; Burns and Grove, 2009:377).

This means that if the same instrument is used, the same results will be obtained on repeated assessments and it is then said to have high reliability (Babbie and Mouton, 2009:119; Bless et al., 2006:150). Reliable instruments improve the power of a study and assist in the identification of important differences or relationships that occur in the population under study (Burns and Grove, 2009:377). De Vos, Strydom, Fouché and Delport (2011:178) are of the opinion that reliability is not concerned with what needs to be measured but with how effective measurement takes place. Therefore the more reliable the application of the instruments, the more reliable the results obtained (De Vos et al., 2011:178). The strategies that were used in order to ensure reliability of the instruments during the data collection process will be discussed.

3.11.1.3.1 Submission of questionnaires to experts

The questionnaires were submitted to the same experts for an evaluation of their reliability. After the questionnaires were scrutinised by the panel of experts, the final instruments were tested by means of a pilot study. No corrections were made after conducting the pilot version of the study and therefore the self-administered questionnaires were used as is.

3.11.1.3.2 Questionnaires in a comprehensible language

In the SAMHS with its multi-cultural contexts the researcher had to ensure that the self-administered questionnaires were written in a language that all respondents could understand. Due to the fact that adherence to the Department of Defenses' language policy was a requirement questionnaires were developed in English.

3.12 ETHICAL ISSUES

The Medical Research Council (MRC) defines ethics as science of criteria, norms and values for human action and conduct. According to the MRC the sole intent is to benefit patients through the promotion of health (MRC:Online). Polit and Beck (2008:753)

describe research ethics as a system of moral values that has to do with the intensity to which research procedures adhere to the professional, legal and social responsibilities of the respondents. Ethical principles provide guidance with regard to acceptable and non-acceptable behaviour during the research process (Burns and Grove, 2009:184). Transgression of ethical principles relates to the reliability of the research results (Brink et al., 2008:31).

Research ethics place a great emphasis on the humane and sensitive treatment of research participants who may be at risk through conducting certain research procedures (Bless et al., 2006:140). Researchers in the health sciences and nursing not only have an ethical responsibility towards the participants but also have the responsibility to collect data with honesty and scientific integrity (Pera and Van Tonder, 2005:151). The researcher was guided by three fundamental ethical principles during the data-gathering phase, namely respect for persons (autonomy), beneficence and justice. These ethical principles are based on human rights that have to be protected during the research study such as the right to self-determination, to privacy, to anonymity and confidentiality, to fair treatment and to being protected from discomfort and harm (Bless et al., 2006:141; Botma et al., 2010:17; Brink et al., 2008:31).

3.12.1 The principle of autonomy (respect for persons)

Respondents that take part in a research study are perceived as the first priority (Pera and Van Tonder, 2005:151). Although researchers have the right to seek the truth, it is not permissible to do it at the expense of the human research respondents (Babbie and Mouton, 2009:520; Burns and Grove, 2009:189). Researchers have an ethical responsibility to take the basic human rights of the respondents into account and to protect these rights at all times (Burns and Grove, 2009:189). Human rights that need to be protected in a research study are the right to self-determination, the right to privacy, the right to anonymity and confidentiality, the right to fair treatment and the right to protection from discomfort and harm (Burns and Grove, 2009:189). The human rights of the respondents will be discussed in detail.

3.12.1.1 Right to self-determination

The right to self-determination is based on the ethical principle of autonomy and implies that respondents have the freedom to decide whether or not to participate in research without any manipulation or prejudicial treatment (Bless et al., 2006:142; Brink et al., 2008:32; Burns and Grove, 2009:189). Respondents' rights to participate voluntarily in research should not be violated. Permission to withdraw from the research study should be granted without any penalty at any time (Brink et al., 2008:32; Burns and Grove, 2009:189). All the respondents were fully informed about the nature of the research study, the benefits and expected outcomes before they voluntarily agreed to participate. The respondents clearly understood that they had the right to withdraw from the study at any time should they prefer to do so and that their decision would be respected. Self-determination can only occur if the respondent is fully enlightened and is allowed to take a well-considered decision. This will be discussed in more detail.

3.12.1.2 Right to be informed

Fundamental to the principle of autonomy is a respondent's right to be informed. They have the right to know what the research entails, how it will influence them, the risks and the benefits and that they may decline to participate in the research should they choose to do so (Bless et al., 2006:142). The researcher was not aware of any risks involved for the respondents. The benefit of the study is that information gathered from the respondents will be utilized in the development of future clinical supervision programmes. Before completion of the questionnaires the research study was explained to each respondent as well as exactly what was required of them. Respondents were given the opportunity to ask questions beforehand.

3.12.1.3 Right to anonymity and confidentiality

Additional to the right of the respondents to anonymity, which means that data must not at any time be linked with their names, they also have the right to assume that

information provided by them, will be protected and will not be made available to anyone other than researchers. The latter is protected through the responsibility to maintain confidentiality of data collected during the research study (Bless et al., 2006:143; Burns and Grove, 2009:197). Maintenance of confidentiality simultaneously ensures that a respondent's right to anonymity is protected (Bless et al., 2006:143). Anonymity on the other hand ensures that respondents are not exploited and that the information that they provide, cannot be used against them (Polit and Beck, 2008:180). The researcher did not at any stage of the research study require the signatures of respondents due to the recommendations made by the Ethics Committee of the UFS's Faculty of Health Sciences. The only identifiable information on the questionnaires was the name of the institution where the respondents worked and the nursing categories they represented. Inclusion of this information was deemed essential because it is connected to the analysis of data.

3.12.1.4 Right to privacy

Respondents have the right to decide to which extent they want to share with or withhold personal information from the researcher. Therefore data cannot be collected from respondents without their knowledge (Burns and Grove, 2009:195). Due to the fact that the anonymity of the respondents was maintained, their right to privacy was not invaded (De Vos et al., 2011:120). Invasion of privacy can also occur when measuring instruments include questions that do not pertain to the research study (Pera and Van Tonder, 2005:154). For this reason the researcher ascertained that all questions included in the questionnaires were focused on the purpose of the study.

The second ethical principle of importance is the principle of beneficence and will be explored in more detail.

3.12.2 The principle of beneficence

According to Polit and Beck (2008:170) beneficence is one of the most fundamental ethical principles in research. To adhere to this principle, the well-being (physical,

emotional, social or financial) of the respondent must be protected from discomfort and harm (Brink et al., 2008:32). Although respondents might be subjected to risks, researchers have the responsibility to minimise discomfort and harm during the study (Babbie and Mouton, 2009:522; Polit and Beck, 2008:170). To apply the principle each respondent was given a questionnaire to complete and was not allowed to discuss their answers with anyone in order to avoid any discomfort in case they revealed sensitive information (Babbie and Mouton, 2009:522). The third ethical principle is the principle of justice and the application thereof will subsequently be discussed.

3.12.3 The principle of justice

The principle of justice means that respondents need to be treated fairly (Botma et al., 2010:19; Polit and Beck, 2008:173) and that any agreements made with them must be respected throughout the study (Brink et al., 2008:33). A respondent's right to privacy is included in the ethical principle and therefore private information need not to be shared with any other person than the researcher. Anonymity and confidentiality were ensured during the research study through the distribution of questionnaires and by requiring the respondents to return them without any identifying details (Brink et al., 2008:34). Respondents were treated fairly by using the random sampling technique and therefore each respondent was granted the same opportunity to be selected during the selection process. A name list of nursing personnel was obtained at the human resource department, after which names were placed into and drawn from a container. No control could be exercised over the respondent names drawn. After data analysis the research results will be published in a report and copies of the report will be made available to the respondents on request.

3.12.4 Ethical validity of the research study

It is the researcher's responsibility to submit the research proposal to the Ethics Committee for review, prior to project initiation (Brink et al., 2008:41). The process not only protects the researcher, but also the respondents (Brink et al., 2008:42). The

research proposal was reviewed by the Ethics Committees of the UFS's Faculty of Health Sciences and the SAMHS for sound scientific methodology, validity and social value (see Annexure E).

3.12.5 Ethical principles with regard to the institution

Before research can commence permission needs to be obtained from the authority of the institution(s) where the research will be conducted. The ethical principles that are applicable to the respondents, also apply to the institutions (Pera and Van Tonder, 2005:154). The Ethics Committee of the SAMHS, the chief executive officers of 1, 2 and 3 Military Hopitals and the principal and vice-principals of the nursing colleges all authorised the research study (see Annexure D).

3.13 DATA ANALYSIS

In quantitative research the focal point is on the statistical analysis of data (Brink et al., 2008:171). With data analysis, collected data is categorised, ordered, manipulated and summarised (Brink et al., 2008:170; Burns and Grove, 2009:695). Although this process does not provide answers, it helps to interpret the collected data (De Vos et al., 2005:218).

Each complete questionnaire was coded, before a biostatistician of the UFS's Department of Biostatistics, assisted with analysis by means of the Statistical Analyses Software (SAS) computer programme. Descriptive statistics were used to describe and summarise the data and measures such as frequency and percentage distributions were obtained.

3.14 CONCLUSION

The purpose of this chapter was to introduce the reader to the research methodology that was followed when conducting the study. A clear motivation for why specific

research methods and techniques were used was written, while the sampling method and the research population were discussed in more detail. Thereafter an overview of the pilot study was given, followed by a flow diagram of the data collection process. Aspects such as reliability, validity and the ethical principles, as important components of scientific research, were debated. The researcher is confident that the proposed research process was meticulously followed and that the consistent application of research principles added value to the study. More information on the research findings will be discussed in the following chapter.

3.15 REFERENCES

BABBIE, E. AND MOUTON, J. 2009. The practice of social research. 9th ed. Cape Town: Oxford University Press.

BLESS, C., HIGSON-SMITH, C. AND KAGEE, A. 2006. Fundamentals of social research methods. 4th ed. Cape Town: Juta & Company.

BOTMA, Y., GREEFF, M., MULAUDZI, F.M. AND WRIGHT, S.C.D. 2010. Research in health sciences. Cape Town: Heinemann.

BURNS, N. AND GROVE, S.K. 2009. The practice of nursing research. 6th ed. Philadelphia: Saunders.

BRINK, H., VAN DER WALT, C. AND VAN RENSBURG, G. 2008. Fundamentals of research methodology for health care professionals. 2nd ed. Cape Town: Juta & Company.

DANIEL, H. 2011. Benefits of everything that matters [online]. Available from: http://benifitofnet/benefits-of-quantitative-research [Accessed 19 July 2012].

DE VOS, A.S., STRYDOM, H., FOUCHé, C.B., AND DELPORT, C.S.L. 2011. Research at grass roots for the social sciences and human services professions. 4th ed. Pretoria: Van Schaik.

HOUSER, J. 2008. Precision, reliability and validity: Essential elements of measurement in nursing research. *Journal for specialists in pediatric nursing*, 13(1):297-299.

MAREE, K. 2007. First steps in research. Pretoria: Van Schaik.

MEDICAL RESEARCH COUNCIL. Guidelines on ethics for medical research: General principles [online]. Available from: http://www.kznhealth.gov.za/research/_ethics1.pdf [Accessed 21 July 2012].

PERA, S.A. AND VAN TONDER, S. 2005. Ethics in health care. 2nd ed. Landsdowne: Juta.

POLIT, D.F. AND BECK, C.T. 2008. Nursing research: Generating and assessing evidence for nursing practice. 8th ed. Philadelphia: Lippincott Williams & Wilkins.

SHUTTLEWORTH, M. 2008. Quantitative research design [online]. Available from: http://www.experiment-resources.com/quantitative-research-design.htlm [Accessed 19 April 2012].

CHAPTER 4

ANALYSIS AND INTERPRETATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

In the previous chapter, attention was given to various aspects of the design of the study and the methodology that was used to obtain sources of information, to collect and analyse the data and to interpret the results. The focus of this chapter is on the results of the collected quantitative data that will be presented and interpreted. The data collected from nurse educators and professional nurses, as well as nursing students and pupil enrolled nurses by means of self-administered questionnaires, were described, analysed and summarised through the aid of descriptive statistics. The biostatistician made use of the SAS computer programme to convert the collected data into frequency distributions.

With data analysis, collected data is categorised, ordered, manipulated and summarised through the implementation of research techniques (Brink, Van der Walt and Van Rensburg, 2008:170; Burns and Grove, 2009:695). Data for the research study was analysed by the biostatistician by means of generating descriptive statistics. Means and standard deviations as well as medians and percentiles were calculated for continuous data while frequencies and percentages were used for categorical data. In this chapter frequency distribution tables, graphics and discussions were used in order to present the content.

4.2 DESCRIPTION OF STATISTICAL ANALYSIS

Collected data are presented in the form of frequency distribution tables from which bar charts are created (Botma, Greeff, Mulaudzi and Wright, 2010:150). The term “frequency” signifies the number of times certain results occur. The occurrence of scores or values of data are added together in order to obtain frequencies. Therefore a

frequency distribution can be defined as a systematic arrangement of scores, from the lowest to the highest, which are linked with the number of times the score occurs. Scores can either be listed separately or may be grouped (Brink et al., 2008, 172). Frequency distributions summarise data and make it more comprehensible (Botma et al., 2010:150).

4.3 SECTION A: DEMOGRAPHIC DATA FOR NURSE EDUCATORS (NE), PROFESSIONAL NURSES (PN), NURSING STUDENTS (NS) AND PUPIL ENROLLED NURSES (PEN)

Data was collected from the four nursing categories in the SAMHS by means of self-administered questionnaires voluntarily completed by the respondents.

This section will serve as an introduction to the biographic data of the different groups of respondents and consists of six questions and six variables, namely gender, age, institutions of respondents' employment, years of service, position and supervision.

Variable 1: Gender

Table 4.1 indicates the number of male and female respondents that participated in the research study. The fact that the majority of the respondents were females indicated the dominance of the gender in the nursing profession. According to the SANC's geographical distribution of manpower (2011:1), the total number of females employed is 26 071 721 and males 24 515 036. The sample size (n=136) including nurse educators (NE) and professional nurses (PN) consisted out of 114 (n=136:84%) female and 22 (n=136:16%) male respondents while the sample size (n=148) for the nursing students (NS) and pupil enrolled nurses (PEN) added up to 90 (n=148:61%) female and 58 (n=148:39%) male respondents.

Table 4.1: The gender of all categories of respondents (Question 1: NE/PN and NS/PEN)

Nursing category	Gender	n	%	Nursing category	Gender	n	%
Nurse educators and professional nurses	Males	22	16	Nursing students and pupil enrolled nurses	Males	58	39
	Females	114	84		Females	90	61
TOTAL		**136**	**100**	**TOTAL**		**148**	**100**

Variable 2: Age

Table 4.2 gives an indication of the age range of the four respondent categories. The mean age for nurse educators (n=18) and professional nurses (n=118) was 38 years and for nursing students (n=104) and pupil enrolled nurses (n=44) 23 years. The majority of the nurse educators and professional nurses, i.e. 42 (n=136:30.88%), were in the age range of 23 to 30 years while 39 (n=136:28.67%) were between 31 and 40 years. Thirty-six (n=136:26.47%) respondents were between the ages of 41 and 50 years, and only 19 (n=136:13.98%) exceeded the age of 51. A total number of 131 (n=148:88.51%) nursing students and pupil enrolled nurses were between the ages of 19 and 30 years, only 9 (n=148:6.08%) between 31 to 40 years of age, and 8 (n=148:41%) exceeded the age of 40, with the oldest respondent 53 years of age.

Table 4.2: Age range of all categories of respondents (Question 2: NE/PN and NS/PEN)

Nursing category	Age range	n	%	Nursing category	Age range	n	%
Nurse educators and professional nurses	23 - 30	42	30.88	Nursing students and pupil enrolled nurses	19 – 30	131	88.51
	31 - 40	39	28.67		31 – 40	9	6.08
	41 - 50	36	26.47		41 – 53	8	5.41
	51 – 64	19	13.98				
TOTAL		**136**	**100**	**TOTAL**		**148**	**100**

Variable 3: Institution of employment for all respondent categories

Table 4.3 shows the number of respondents from each hospital and nursing college that participated in the research study. A total amount of 18 nurse educators participated voluntarily, of which 10 (n=18:56%) were appointed at the nursing college in Thaba Tshwane and 4 (n=18:22%) at each of the nursing colleges in Bloemfontein and Cape Town respectively. Only 46 (n=118:39%) of the professional nurses employed at 1 Military Hospital agreed to complete the self-administered questionnaires, while respectively 42 (n=118:36%) and 30 (n=118:25%) professional nurses at 2 Military and 3 Military Hospitals took part. Nursing students (n=104) were more willing to participate in the research study than the nurse educators (n=18) and professional nurses (n=118). A total of 104 (n=148:70.28%) of the nursing students participated voluntarily, of which 61 comprised first-year students, 17 second-year and 26 fourth-year students. At the nursing college in Bloemfontein, 10-year and 12 second-year (22:n=148:14.86%) students completed questionnaires. At the nursing college in Cape Town, 12 first-year and 10 second-year (22:n=148:14.86%) students participated voluntarily.

Table 4.3: Institution of employment for all respondent categories (Question 3: NE/PN and NS/PEN)

Nursing category	Hospital/Nursing college	n	%	Nursing category	Hospital/Nursing college		n	%
Nurse educators	Nursing College: Thaba Tshwane	10	56	Nursing students	Thaba Tshwane Main Campus	1st year	61	70.28
						2nd year	17	
						4th year	26	
	Nursing College: Bloemfontein	4	22					
	Nursing College: Cape Town	4	22					
			100					
Professional nurses	1 Military Hospital	46	39	Pupil enrolled nurses	Nursing college: Bloemfontein		22	14.86
	2 Military hospital	42	36		Nursing college: Cape Town		22	14.86
	3 Military hospital	30	25					
TOTAL		**136**	**100**				**148**	**100**

Variable 4: Years of service for the different nursing categories (Question 4: NE/PN and Question 5: NS and PEN)

Table 4.4 shows the number of years of service of respondents in the SAMHS. Nurse educators and professional nurses with 1 to 5 years of service added up to 70 (n=136:51.48%) and those between 6 to 10 years came to a total of 21 (n=136:15.44%). Only 10 (n=136:7.35%) had served in the SAMHS between 11 and 15 years, 24 (n=136:17.65%) between 16 to 20 years, 7 (n=136:5.15%) between 21 to 25 years, 1 (n=136:0.73%) between 26 and 30 years, 1 (n=136:0.73%) between 31 to 35 years and 2 (n=136:1.47%) respondents had between 36 and 40 years of service. From the students (n=148) who participated in the research study, 121 (n=148:81.76%) had 1 to 5 years of service, and only 15 (n=148:10.14%) had served in the military for between 6 and 10 years. A minority of 3 (n:148:2.02%) respondents had 11 to 15 years of service and 9 (n=148:6.08%) had 16 to 20 years of service.

Table 4.4: Years of service for all respondent categories (Question 4)

Service as: Nurse educator/ professional nurse	n	%	Service as: Nursing student/ Pupil enrolled nurse	n	%
1-5	70	51.48	1 - 5	121	81,76
6-10	21	15.44	6-10	15	10.14
11-15	10	7.35	11-15	3	2,02
16-20	24	17.65	16-20	9	6,08
21-25	7	5.15			
26-30	1	0.73			
31-35	1	0.73			
36-40	2	1.47			
TOTAL	**136**	**100**	**TOTAL**	**148**	**100**

Variable 5: Number and position of all respondent categories

Table 4.5 gives an indication of the number of nurse educators (n=18:13.24%), professional nurses (n=118:86.76%), nursing students (n=104:70.27%) and pupil enrolled nurses (n=44:29.73%) who offered that voluntary participation in the research study and the positions they were appointed in.

Table 4.5: Number and position of all respondent categories (Question 5: NE/PN and Question 6: NS/PEN)

Number of:	n	%	Number of:	n	%
Nurse educators	18	13.24	Nursing students	104	70.27
Professional nurses	118	86.76	Pupil enrolled nurses	44	29.73
TOTAL	**136**	**100**	**TOTAL**	**148**	**100**

Variable 6: Supervision

Table 4.6 shows the nursing categories that nurse educators (n=18) and professional nurses (n=118) supervised in the clinical setting. A total number of 56 (n=136:41.17%) nurse educators and professional nurses indicated that they supervised nursing students in the clinical learning environment while 80 (n=136:58.83%) of the nurse educators and professional nurses supervised pupil enrolled nurses.

Table 4.6: Categories of students supervised by nurse educators and professional nurses (Question 6: NE/PN)

Nursing category supervised by:	n	%	Nursing category supervised:	n	%
Nurse educators and professional nurses	56	41.17	Nursing students	104	70.27
Nurse educators and professional nurses	80	58.83	Pupil enrolled nurses	44	29.73
TOTAL	136	100		148	100

4.4 SECTIONS B AND C: CLINICAL SUPERVISION BY NURSE EDUCATORS (NE) AND PROFESSIONAL NURSES (PN)

The following sections give a clear indication of the amount of time that nurse educators and professional nurses spent with nursing students and pupil enrolled nurses in the SAMHS clinical learning environment. A question was posed on which category respondents feel need to take responsibility for clinical supervision. The four nursing categories were requested to state what factors influenced the time that nurse educators and professional nurses spent with them in the clinical setting and the suggestions they had with regard to clinical supervision.

One of the SANC's requirements (Regulation 425 as amended by R753 of 22 April 1988) is that nurse educators and professional nurses have to spend half an hour every fortnight on clinical supervision per student.

Figure 4.1 shows the response of nurse educators and professional nurses (n=136:100%) with regard to the time they had spent with nursing students (n=104:100%) in the clinical setting during the months of January until April 2011. For January 2011 51 (n=136:37.5%) of the nurse educators and professional nurses agreed that they did not spend time on clinical supervision. The reason for this might be that the majority of employees in the SAMHS were granted vacation leave during the months of December and January. A minority of 12 (n=136:8.9%) of the nurse educators and professional nurses did not spend more than half an hour per month in clinical supervision with nursing students while 22 (n=136:16.1%) spent between half an hour but less than one hour on clinical supervision. Only 32 (n=136:23.2%) of the respondents met the SANC requirements by spending more than one hour on clinical supervision but less than two hours per month per student. The remaining 19 (n=136:14.3%) of the nurse educators and professional nurses exceeded the requirements stipulated by the SANC and revealed that they spent more than two hours per month per student in the clinical setting.

During the month of February 2011, 31 (n=136:23.2%) of the nurse educators and professional nurses did not allocate time for clinical supervision, while 12 (n=136:8.9%) spent less than half an hour per nursing student per month. A total of 39 (n=136:28.6%) of the nurse educators and professional nurses spent half an hour but less than one hour per month with nursing students in the clinical setting. Only 32 (n=136:23.2%) of the nurse educators and professional nurses met the SANC requirements for clinical supervision and spent more than one hour but less than two hours. Furthermore 22 (n=136:16.1%) indicated that they had spent more than two hours per month supervising students.

A total of 39 (n=136:28.6%) of the nurse educators and professional nurses indicated not having spent time with nursing students in the clinical setting during March 2011 and 10 (n=136:7.1%) had supervised students for less than half an hour per month. Only 43 (n=136:32.1%) of the clinical supervisors had spent more than half an hour but less than two hours on clinical supervision in the learning environment. Nurse educators and professional nurses that had indeed met the SANC requirements added up to 22 (n=136:16.1%) while the same number stated that they had facilitated clinical learning by spending more than two hours per nursing student per month.

Data obtained for April 2011 reflects that 29 (n=136:21.4%) of the nurse educators and professional nurses did not facilitate clinical learning and 17 (n=136:12.5%) indicated that they spent less than half an hour per month on clinical supervision. A total of 44 (n=136:32.1%) indicated that they spent more than half an hour but less than one hour with nursing students in the clinical learning environment while 17 (n=136:12.5%) indicated that they supervised students in the clinical setting for longer than one hour but shorter than two hours. Only 29 (n=136:21.5%) of the nurse educators and professional nurses managed to spend more than two hours per month supervising students.

In Figure 4.1 one can conclude that only 26 (n=136:18.75%) of the nurse educators and professional nurses who participated in the research study complied with the SANC requirements of spending more than one hour but less than two hours on clinical supervision of nursing students in the clinical learning environment. By adding the percentages for January, February, March and April 2011, an average 18.75% is calculated for nurse educators and professional nurses who spent more than one hour but less than two hours supervising students in the clinical setting while a total of 23 (n=136:17%) of the nurse educators and professional nurses spent more than two hours per student.

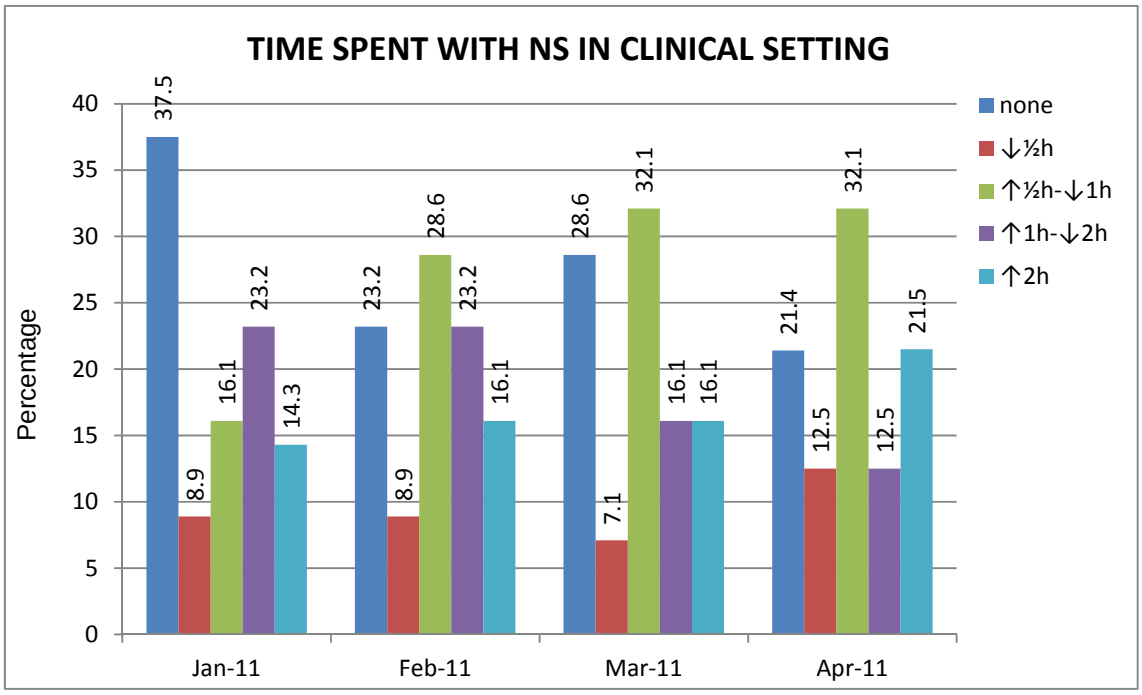

Figure 4.1: The response of nurse educators (NE) and professional nurses (PN) with regard to the amount of time spent with nursing students (NS) per month in the clinical learning environment (Section B: Question 1: NE/PN)

Figure 4.2 signifies the amount of time that nurse educators and professional nurses indicated they spent with pupil enrolled nurses in the clinical setting.

For January 2011, 61 (n=136:45%) of the nurse educators and professional nurses revealed that they had not spent time with pupil enrolled nurses in the clinical setting due to the fact that the majority of students were still on vacation leave. Only 10 (n=136:7.4%) of the clinical supervisors revealed that they spent less than half an hour supervising pupil enrolled nurses and 12 (n=136:8.8%) facilitated clinical supervision and had spent more than half an hour but less than one hour per month. A total of 19 (n=136:13.8%) indicated that they supervised pupil enrolled nurses for longer than one hour but less than two hours per month, while 34 (n=136:25%) of the nurse educators and professional nurses exceeded the SANC requirements by spending more than two hours per month per pupil enrolled nurse.

For the months of February and March 2011, respectively 49 (n=136:36.3%) and 56 (n=136:41.2%) of the pupil enrolled nurses had not been facilitated in the clinical learning environment, while 10 (n=136:7.4%) and 7 (n=136:5%) of the clinical supervisors spent less than half an hour on clinical supervision. Only 19 (n=136:13.8%) of the nurse educators and professional nurses indicated having spent between half an hour but less than one hour on clinical supervision during February 2011 and 15 (n=136:11.3%) during March of the same year. For February 2011, a total of 17 (n=136:12.5%) of the pupil enrolled nurses reported being supervised by nurse educators and professional nurses for longer than one hour but less than two hours, and during March 2011 this was a number of 15 (n=136:11.3%). A total of respectively 41 (n=136:30%) and 42 (n=136:31.2%) of the nurse educators and professional nurses had spent more than the required SANC hours supervising with pupil enrolled nurses in February and March 2011.

For April of the same year, 46 (n=136:33.7%) of the pupil enrolled nurses had not been supervised in the clinical setting while 7 (n=136:5%) reported being supervised for less than half an hour by nurse educators and professional nurses. Only 20 (n=136:15%) of the latter category had supervised pupil enrolled nurses for more than half an hour but less than one hour. A total of 17 (n=136:12.5%) of the pupil enrolled nurses received clinical supervision of longer than one hour but shorter than two hours per month from nurse educators and professional nurses. Only 46 (n=136:33.8%) of the nurse educators and professional nurses managed to supervise pupil enrolled nurses for longer than two hours.

According to Figure 4.2 it may be deduced that 13 (n=136:50.1%) of the nurse educators and professional nurses who participated in the research study adhered to the SANC requirements with regard to clinical supervision of pupil enrolled nurses by spending more than one hour but less than two hours on clinical supervision, while a total of 30 (n=136:120%) spent more than two hours per student. Percentages were calculated by adding the totals together for the months of January to April 2011 and dividing the sum by 4.

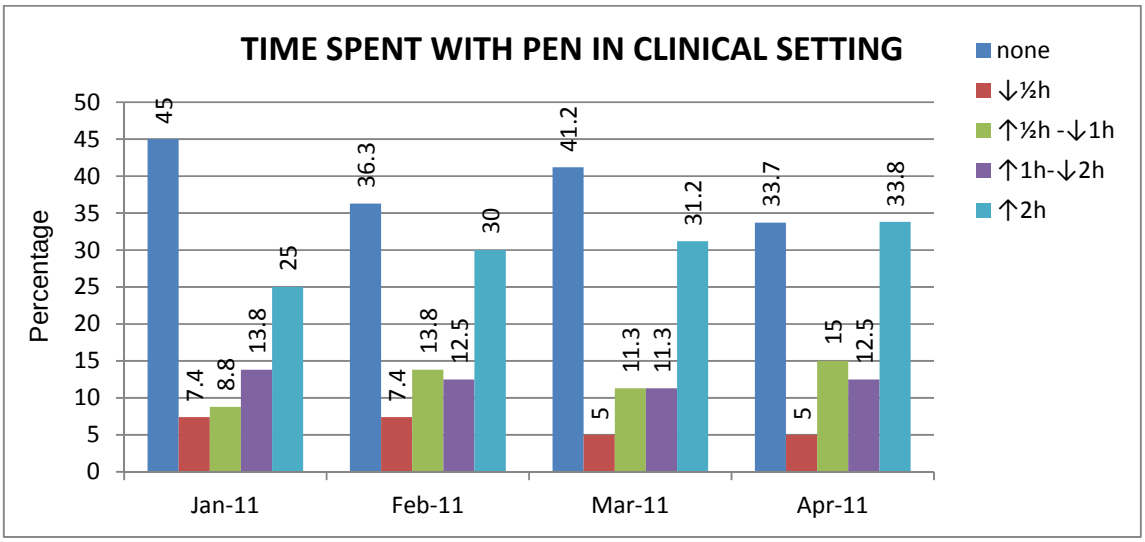

Figure 4.2: The response of nurse educators (NE) and professional nurses (PN) with regard to the time spent with pupil enrolled nurses (PEN) per month in the clinical learning environment (Section C: Question 1: NE/PN)

Figure 4.3 gives an indication of the responses of nursing students and pupil enrolled nurses with regard to the amount of time that nurse educators spent with them in the clinical setting from January until April 2011.

The vast majority of 114 (n=148:77%) of nursing students and pupil enrolled nurses revealed that they had not been supervised by nurse educators in the clinical setting during January, the possible reason being that a large number of nurse educators, nursing students and pupil enrolled nurses were still on vacation leave. A total of 13 (n=148:8.7%) of the nursing students and pupil enrolled nurses stated that nurse educators spent less than half an hour with them in the clinical learning environment, while 6 (n=148:4.1%) indicated that nurse educators spent more than half an hour but less than one hour per month with them. Only 5 (n=148:3.4%) of the nursing students and pupil enrolled nurses revealed that nurse educators managed to spend longer than one hour but less than two hours with them in the clinical setting. The nurse educators who spent more than two hours per nursing student and pupil enrolled nurse on clinical supervision, totaled 10 (n=136:6.8%).

For February and March 2011, 88 (n=148:60%) of the nursing students and pupil enrolled nurses' learning had not been facilitated in the clinical learning environment. A total of 25 (n=148:16.8%) of the latter category were supervised by nurse educators in the clinical setting, while 16 (n=148:10.6%) of the students indicated that nurse educators spent more than half an hour but less than one hour per month with them. Only 3 (n=148:2%) of the nursing students and pupil enrolled nurses were supervised by nurse educators for longer than one hour but less than two hours per month. The total of nursing students and pupil enrolled nurses who were exposed to clinical supervision for more than two hours per month came to a total of 16 (n=148:10.6%).

For March 2011, 13 (n=148:8.6%) of the nursing students and pupil enrolled nurses revealed that they had been supervised for less than half an hour in the clinical learning environment, while 19 (n=148:12.7%) stated that nurse educators had managed to supervise them for longer than half an hour but less than one hour. A total of 12 (n=148:7.7%) of the nursing students and pupil enrolled nurses were supervised by nurse educators for more than one hour but less than two hours per month and 16 (n=148:11%) were supervised for more than two hours per month.

For April 2011, 83 (n=148:56.1%) of the nursing students and pupil enrolled nurses had not received any supervision from nurse educators in the clinical setting. A total of 15 (n=148:10.1%) had been supervised for less than half an hour while 17 (n=148:11.5%) of the nursing students and pupil enrolled nurses were facilitated for more than half an hour but less than two hours. Only 16 (n=148:10.8%) of the nursing students and pupil enrolled nurses indicated that nurse educators had managed to exceed the SANC requirements by being supervised for more than two hours per month.

In Figure 4.3 the conclusion can be made that more than 50%, namely an average of 63.3%, of the nursing students and pupil enrolled nurses in the SAMHS had not been supervised by nurse educators in the clinical learning environment during the months of January, February, March and April 2011. By adding the percentages for the months

mentioned and dividing the sum of the total by four (4), this average of 63.3% (n=148:94) was calculated.

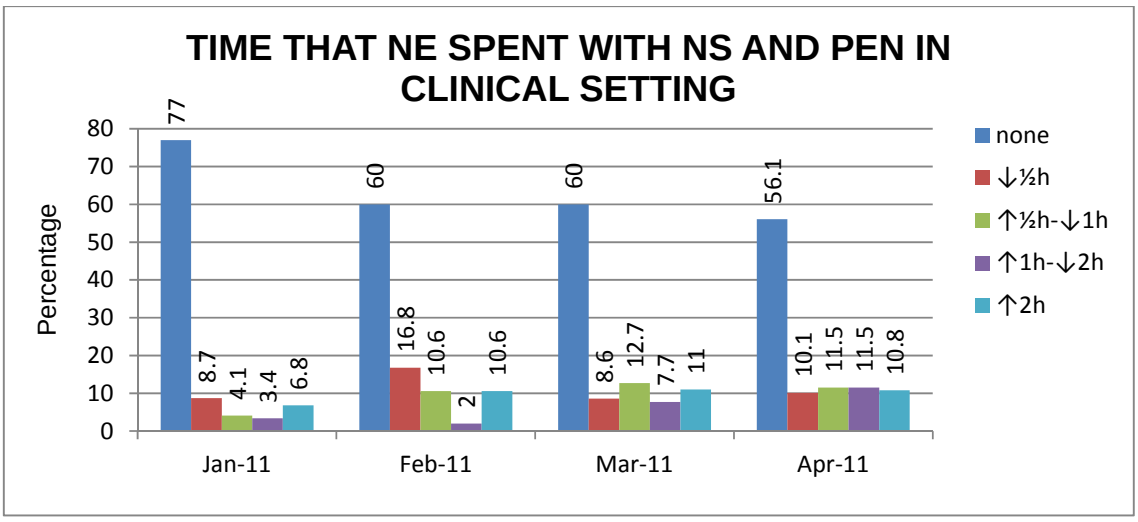

Figure 4.3: The response of nursing students (NS) and pupil enrolled nurses (PEN) with regard to the time per month that nurse educators (NE) spent with them in the clinical learning environment (Section B: Question 1: NS/PEN)

Figure 4.4 indicates the amount of time that the participating professional nurses, spent with nursing students and pupil enrolled nurses in the clinical setting.

The vast majority of nursing students and pupil enrolled nurses revealed that no time had been spent with them whilst in the clinical setting. A total of 81 (n=148:54.8%) of the nursing students and pupil enrolled nurses stated that they had not been supervised by professional nurses during January 2011 while 14 (n=148:9.7%) received less than half an hour of clinical supervision. Only 17 (n=148:11.6%) of the nursing students and pupil enrolled nurses stated that professional nurses supervised them for longer than half an hour but less than one hour per month. Professional nurses managed to supervise 10 (n=148:6.9%) of the nursing students and pupil enrolled nurses for more than one hour but less than two hours, while 26 (n=148:17%) of the latter category had been supervised for more than two hours per month in the clinical learning environment.

For February 2011, 66 (n=148:44.8%) of the nursing students and pupil enrolled nurses did not receive any clinical supervision while 13 (n=148:8.8%) revealed that professional nurses in the clinical setting had facilitated their clinical learning for less than half an hour per month. A total of 24 (n=148:16.4%) of the nursing students and pupil enrolled nurses indicated that clinical supervision had been conducted by professional nurses for more than half an hour but less than one hour. Only 15 (n=148:9.7%) of the nursing students and pupil enrolled nurses indicated that professional nurses in the SAMHS had managed to supervise them for more than one hour but less than two hours per month while 30 (n=148:20.3%) of the nursing students and pupil enrolled nurses stated that clinical supervision had been conducted for longer than two hours per month.

For the month of March 2011, 81 (n=148:54.9%) of the nursing students and pupil enrolled nurses indicated that professional nurses had not spent time with them in the clinical learning environment while 12 (n=148:7.8%) stated that supervision had taken place for less than half an hour per student per month. Only 17 (n=148:11.7%) of the nursing students and pupil enrolled nurses indicated that professional nurses had attended to them in the clinical setting for more than half an hour but less than one hour. A total of 19 (n=148:12.8%) of the nursing students and pupil enrolled nurses revealed that professional nurses had spent more than one hour but less than two hours with them and the same percentage stated that they had been supervised for more than two hours per month.

Data obtained for April 2011, reflected that 83 (n=148:56.1%) of the nursing students and pupil enrolled nurses had not been supervised in the clinical setting and 15 (n=148:10.1%) indicated that nurse educators and professional nurses had spent less than half an hour per month on clinical supervision. A total of 17 (n=148:11.5%) of the nurse educators and professional nurses spent more than half an hour but less than one hour with nursing students and pupil enrolled nurses in the clinical learning environment while 17 (n=148:11.5%) indicated that they had supervised students for longer than one hour but less than two hours.

Only 16 (n=148:10.8%) of the nurse educators and professional nurses managed to spend more than two hours per month supervising students.

In figure 4.4 the conclusion can be made that more than 70 (n=148:47%) of the nursing students and pupil enrolled nurses employed in the SAMHS were not supervised by professional nurses in the clinical learning environment during the months of January, February, March and April 2011. This average percentage of 47% (n=148:70) was calculated by adding the total of all the nursing students and pupil enrolled nurses who had not received any clinical supervision and the sum of the total was divided by 4.

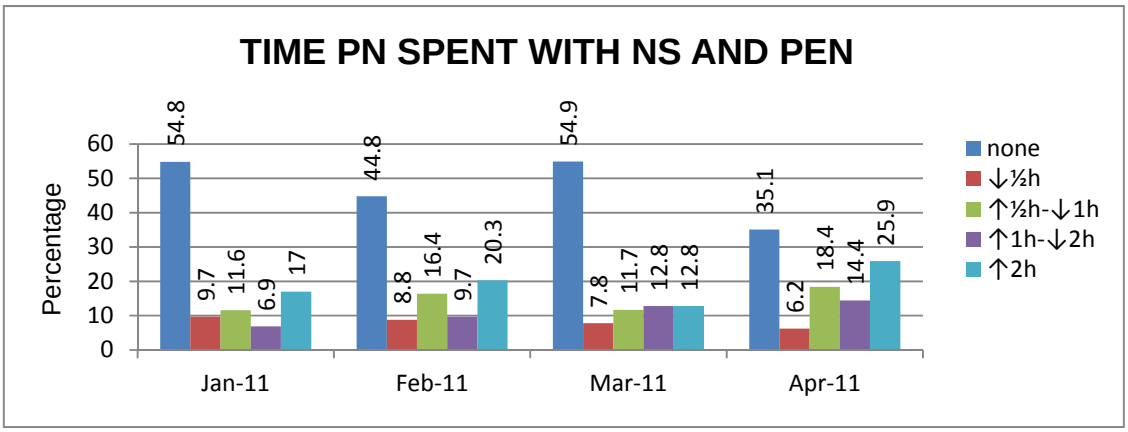

Figure 4.4: The response of nursing students (NS) and pupil enrolled nurses (PEN) with regard to the amount of time per month professional nurses (PN) spent with them in the clinical learning environment (Section B: Question 3: NS/PEN)

In Figures 4.5 to 4.8, 13 different reasons were identified for why nurse educators and professional nurses spent half an hour or no time supervising nursing students. These reasons included administrative tasks, staff shortages, a heavy workload, lecturing etc.

For January 2011, 13 (n=136:9.4%) nurse educators and professional nurses reported attending a course, performed clinical assessments or administrative tasks while 21 (n=136:15.6%) stated that they were still on leave. A total of 9 (n=136:6.3%) of the nurse educators reported that they were lecturing, while professional nurses gave in-service training, had been appointed after the survey dates or experienced staff shortages in the clinical setting. Only 4 (n=136:3.1%) of the professional nurses

reported being scheduled for night duty or considered the practical setting too busy to attend to clinical supervision, while some revealed that the ratio between the nurse educators and the nursing students needed adjustment. Seeing that question 2 and question 4 of Section B were open-ended questions, nursing students were granted the opportunity to give more than one answer meaning that the total percentage could not add up to 100%.

The conclusion that can be made with regard to the most prominent reasons for non-supervision in January 2011, is that nurse educators and professional nurses had either been on leave, had been attending courses, performing clinical assessments or administrative tasks.

For February 2011, 4 (n=136:3.1%) of the nurse educators and professional nurses reported having attended courses, being on leave, being busy with clinical assessments, having been appointed after the survey dates, having worked night duty, and experiencing staff shortages or heavy workloads in the clinical setting. A total of 9 (n=136:6.3%) of the nurse educators and professional nurses were either lecturing or conducting in-service training and confessed that the ratio between nursing students and nurse educators had to be adjusted. Only 13 (n=136:9.4%) of the nurse educators and professional nurses cited being busy with administrative tasks as a reason not spending a lot of time on clinical supervision. Questions 2 and 4 of Section B were open-ended questions, meaning that nursing students could supply more than one answer. This explains why the total percentage could not add up to 100%.

The most prominent reasons for non-supervision in February 2011 were that nurse educators and professional nurses were occupied with administrative tasks or had to lecture students. Another reason for non-supervision was that the nurse educator versus nursing student ratio still had to be adjusted.

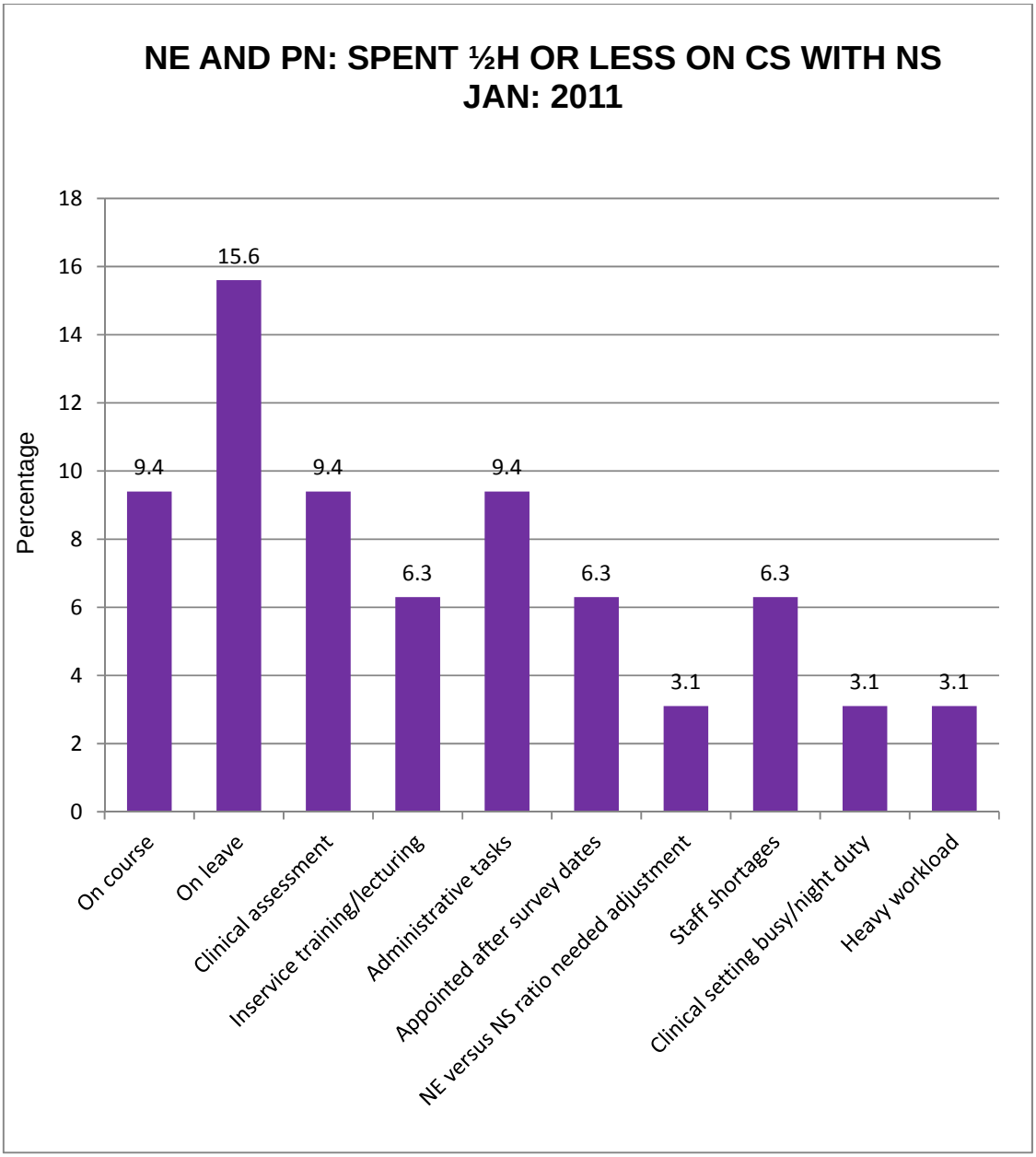

Figure 4.5: Various reasons why nurse educators (NE) and professional nurses (PN) spent half an hour or less on clinical supervision (CS) with nursing students (NS) during January 2011 (Section B: Question 2 and Question 4: NS/PEN)

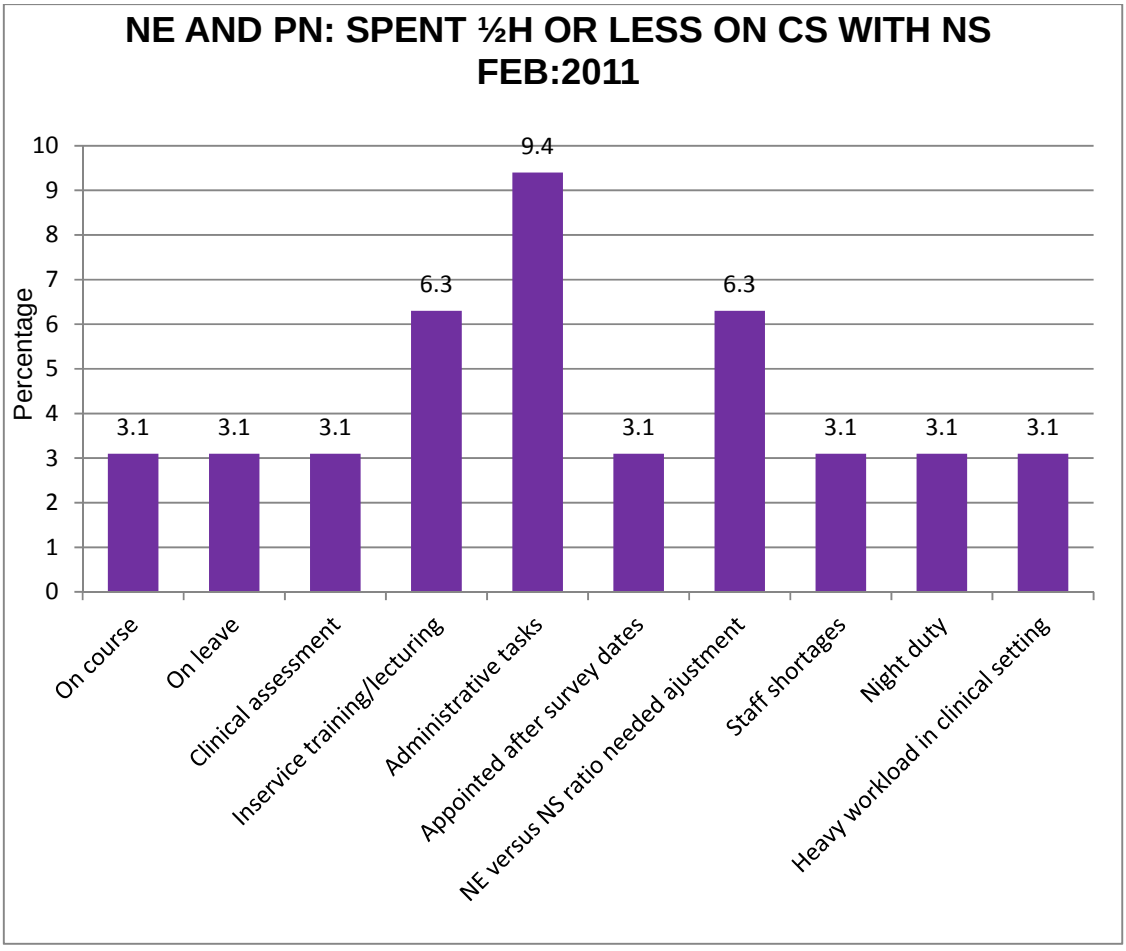

Figure 4.6: Various reasons why nurse educators (NE) and professional nurses (PN) spent half an hour or less on clinical supervision (CS) with nursing students (NS) during February 2011 (Section B: Question 2 and Question 4: NS/PEN)

For March 2011, 4 (n=136:3.1%) of the nurse educators and professional nurses reported being on leave, having lectured or conducted in-service training, having experienced staff shortages or heavy workloads in the clinical setting, or having been scheduled for night duty. Only 26 (n=136:18.8%) stated that they had performed clinical assessments with nursing students in the clinical setting. Administrative tasks hindered 9 (n=136:6.3%) of the nurse educators and professional nurses from attending to clinical supervision and they revealed that the ratio between the nurse educators and nursing students needed adjustment. A total of 13 (n=136:9.4%) were newly appointed members in the SAMHS. The fact that questions 2 and 4 of Section B were open-ended

questions meant that nursing students were allowed to supply more than one answer. Therefore the total percentage could not add up to 100%.

The most important reason for non-supervision in March 2011 was that nurse educators reported having performed clinical assessments with nursing students in the clinical learning environment.

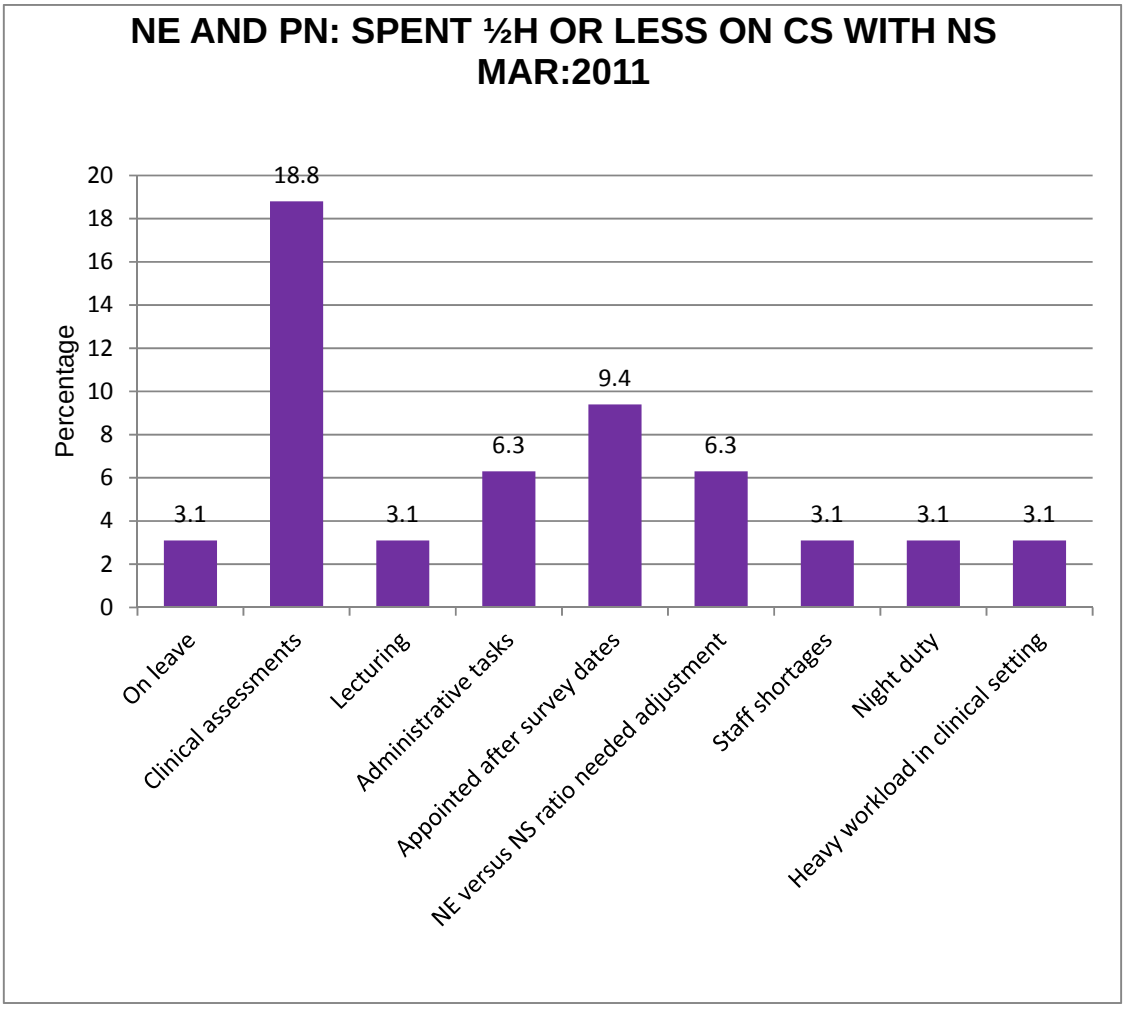

Figure 4.7: Various reasons why nurse educators (NE) and professional nurses (PN) spent half an hour or less on clinical supervision (CS) with nursing students (NS) during March 2011 (Section B: Question 2 and Question 4: NS/PEN)

For the month of April 2011, 4 (n=136:3.1%) of the nurse educators and professional nurses reported having attended courses or being on leave, performing clinical assessments, presenting lectures or in-service training, being busy with administrative tasks, working night duty or stated that they did not know the students allocated to their clinical department. A total of 9 (n=136:6.3%) of the nurse educators and professional nurses were appointed by the SAMHS only after the survey dates. Heavy workloads in the clinical setting were cited by 9 (n=136:6.3%) of the respondents who also confessed that no clear guidelines were available for the clinical supervision of nursing students. A total of 17 (n=136:12.5%) of the nurse educators and professional nurses reported experiencing insufficient time for attending to clinical supervision as a result of all the additional tasks that they were expected to execute in their departments. Questions 2 and 4 of Section B were open-ended questions and nursing students were permitted to give more than one answer, meaning that the total percentage could not add up to 100%.

One of the most important reasons for non-supervision in April 2011 was that nurse educators and professional nurses experienced a lack of time for supervising nursing students in the clinical learning environment.

Figures 4.5 to 4.8 reveal that the most significant factors that inhibited nurse educators and professional nurses from supervising nursing students in the clinical learning environment constituted being on leave, administrative tasks, clinical assessments and a lack of time for to supervising students.

Figures 4.9 to 4.12 give an indication of various reasons why nurse educators and professional nurses spent only half an hour or no time per month supervising pupil enrolled nurses in the clinical setting.

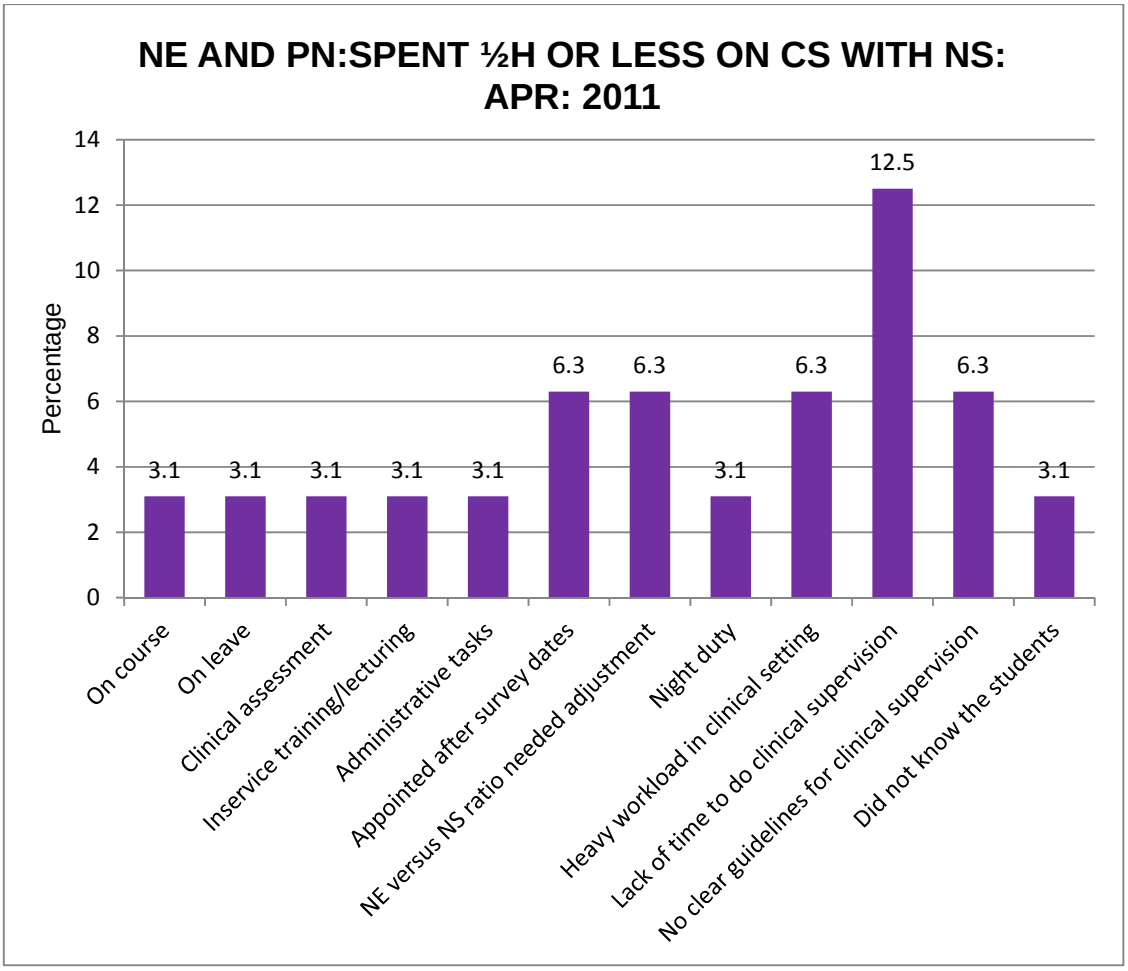

Figure 4.8: Various reasons why nurse educators (NE) and professional nurses (PN) spent half an hour or less per month on clinical supervision (CS) with nursing students (NS) during April 2011 (Section B: Question 2 and Question 4: NS/PEN)

For January 2011, 27 (n=136:20%) of the nurse educators and professional nurses reported being on leave. A total of 8 (n=136:6%) of the nurse educators and professional nurses stated that pupil enrolled nurses knew what was expected of them in the clinical setting and therefore did not receive any clinical supervision. Only 3 (n=136:2%) of the nurse educators and professional nurses felt that it was not necessary to supervise with pupil enrolled nurses, while 8 (n=136:6%) reported that pupil enrolled nurses could be supervised by other nursing categories such as enrolled nurses. A total of 19 (n=136:14%) of the nurse educators and professional nurses reported having been deployed and 24 (n=136:18%) stated that pupil enrolled nurses had not been allocated to their departments during this period. Professional nurses who

were still undergraduates at the time of the survey totaled 16 (n=136:12%), while 3 (n=136:2%) reported that they had attended courses, experienced staff shortages in the clinical setting or had conducted on-the-spot training with pupil enrolled nurses. Seeing that question 2 of Section B was an open-ended question, nursing students were allowed to give more than one answer, which explains why the total percentage could not add up to 100%.

The most important reason for non-supervision of pupil enrolled nurses in January 2011 was that nurse educators and professional nurses were still on leave. Another reason for non-supervision was that students had not been allocated to their specific clinical learning area.

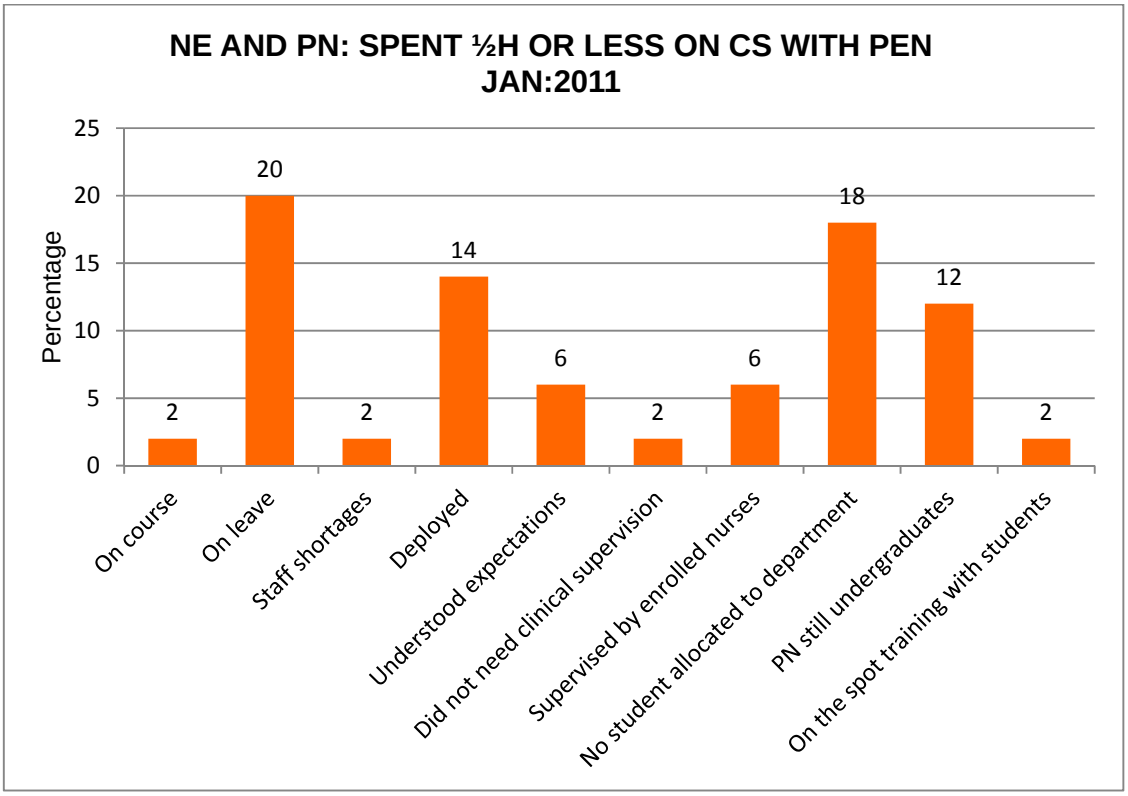

Figure 4.9: Various reasons why nurse educators (NE) and professional nurses (PN) spent half an hour or less per month on clinical supervision (CS) with pupil enrolled nurses (PEN) during January 2011 (Section B: Question 2 and Question 4: NS/PEN)

For February 2011, 8 (n=136:6%) of the nurse educators and professional nurses reported being on leave, while 5 (n=136:4%) revealed that no clinical supervision was provided to pupil enrolled nurses because the latter knew what was expected from them in the clinical setting. A total of 8 (n=136:6%) of the nurse educators and professional nurses reported not paying any attention to clinical supervision and allowed enrolled nurses to continue with the task. Only 11 (n=136:8%) of the nurse educators and professional nurses reported having been deployed and 24 (n=136:18%) of the respondents said that pupil enrolled nurses had not been allocated to their departments during the month of February 2011. A total of 16 (n=136:12%) of the professional nurses were still undergraduates at the time of the survey, while 3 (n=136:2%) reported having worked night duty, attending courses, not needing clinical supervision and experiencing staff shortages. Five (n=136:4%) of the nurse educators and professional nurses reported that they had conducted on-the-spot training with pupil enrolled nurses. Questions 2 and 4 of Section B were open-ended questions, which meant that pupil enrolled nurses were allowed to provide more than one answer. This explains why the total percentage could not add up to 100%.

The main reason for non-supervision of pupil enrolled nurses in February 2011, according to nurse educators and professional nurses, was that no students had been allocated to their clinical areas.

For March 2011, 8 (n=136:6%) of the nurse educators and professional nurses were on leave. A total of 11 (n=136:8%) said that pupil enrolled nurses knew what was expected of them in the clinical setting, while 5 (n=136:4%) stated that pupil enrolled nurses did not need supervision in the clinical setting. Only 24 (n=136:18%) revealed that they were deployed during this period and 16 (n=136:12%) said that pupil enrolled nurses were trained by other nursing categories such as enrolled nurses. The nurse educators and professional nurses who stated that pupil enrolled nurses had not been allocated to their departments totaled 19 (n=136:14%), while 3 (n=136:2%) were still undergraduates.

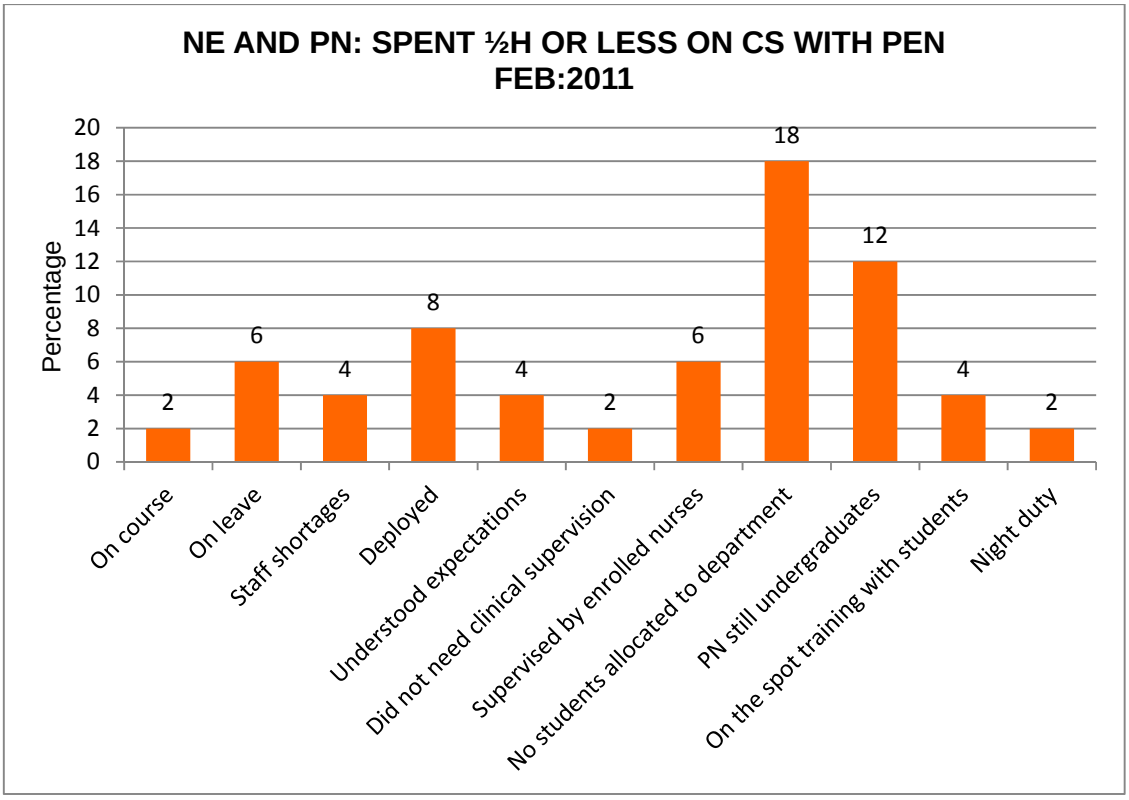

Figure 4.10: Various reasons why nurse educators (NE) and professional nurses (PN) spent half an hour or less per month on clinical supervision (CS) with pupil enrolled nurses (PEN) during February 2011 (Section B: Question 2 and Question 4: NS/PEN)

A total of 3 (n=136:2%) of the nurse educators and professional nurse reported attending courses or conducting on-the-spot training or said that they were not familiar with the pupil enrolled nurses and thus did not supervise them. Due to the fact that questions 2 and 4 of Section B were open-ended questions, pupil enrolled nurses were permitted to give more than one answer. Thus the total percentage could not add up to 100%.

One of the most important reasons for non-supervision of pupil enrolled nurses during March 2011 was that nurse educators and professional nurses had been deployed. Other reasons for non-supervision were that pupil enrolled nurses had not been allocated to the specific clinical learning area or were supervised by enrolled nurses.

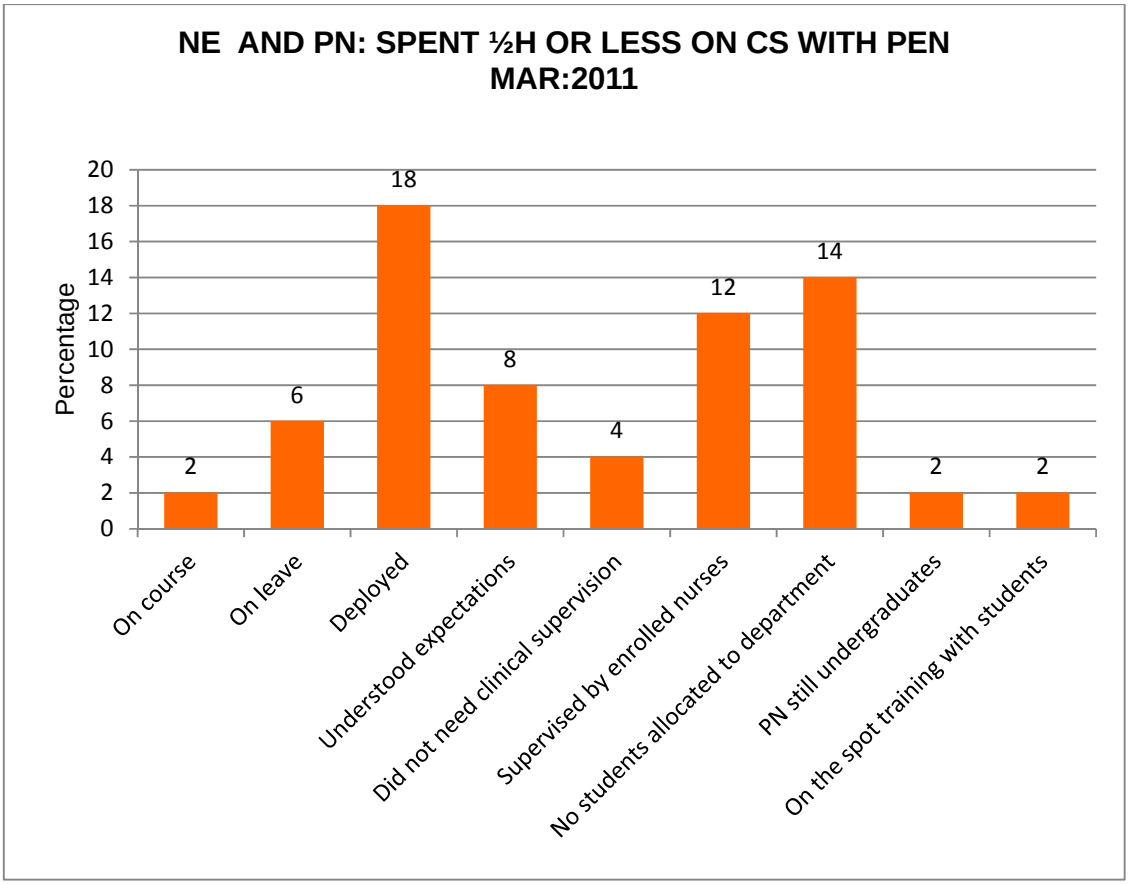

Figure 4.11: Various reasons why nurse educators (NE) and professional nurses (PN) spent half an hour or less per month on clinical supervision (CS) with pupil enrolled nurses (PEN) during March 2011 (Section B: Question 2 and Question 4: NS/PEN)

For the month of April 2011, 5 (n=136:4%) of the nurse educators and professional nurses were on leave. Only 5 (n=136:4%) of the latter category stated that pupil enrolled nurses did not need clinical supervision because they knew what was expected of them in the clinical setting, while 3 (n=136:2%) of the nurse educators and professional nurses allowed enrolled nurses to supervise pupil enrolled nurses. A total of 14 (n=136:10%) of the nurse educators and professional nurses were deployed during this period and 24 (n=136:18%) said that no pupil enrolled nurses had been allocated to their departments during this period. A total of 16 (n=136:12%) of the professional nurses claimed to be still nursing students at the time of the survey conducted and 3 (n=136:2%) reported having attended courses, experiencing staff shortages, performing administrative tasks or conducting only on-the-spot training.

Question 2 and question 4 of Section B were open-ended questions and pupil enrolled nurses could supply more than one answer. Thus the total percentage could not add up to 100%.

The most important reasons for non-supervision of pupil enrolled nurses in April 2011 constituted deployment, professional nurses being undergraduates and the fact that students had not been allocated to the relevant clinical learning areas.

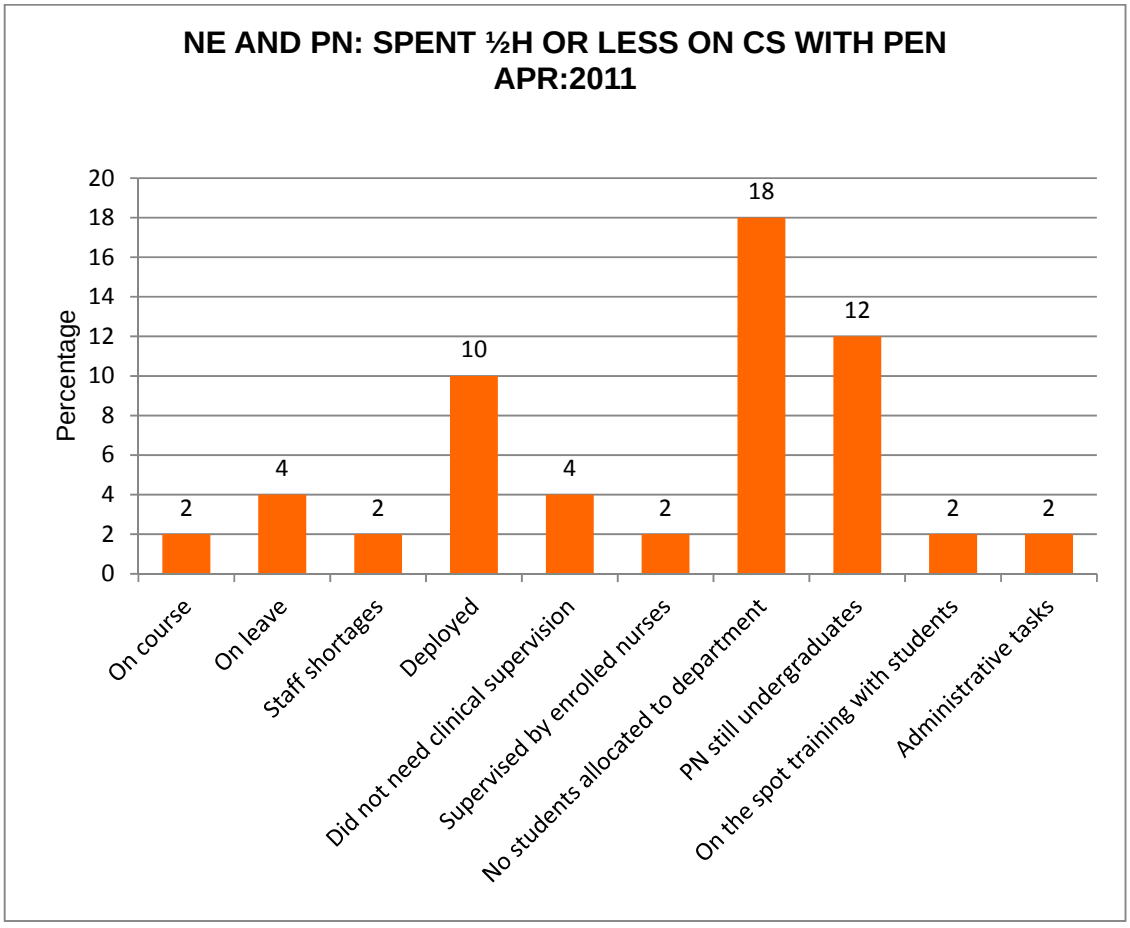

Figure 4.12: Various reasons why nurse educators (NE) and professional nurses (PN) spent half an hour or less per month on clinical supervision (CS) with pupil enrolled nurses (PEN) during April 2011 (Section B: Question 2 and Question 4: NS/PEN)

Figure 4.9 to 4.12 reveal that the most important factors that inhibiting nurse educators and professional nurses from supervising pupil enrolled nurses in the clinical setting

constitute leave, the fact that those students are not allocated to specific departments, deployment and supervision by enrolled nurses.

Figures 4.13 to 4.16 depict the responses of nursing students and pupil enrolled nurses regarding why they think nurse educators spent only half an hour or none per month with them in the clinical setting.

For January 2011, a total of 70 (n=148:47%) of the nursing students and pupil enrolled nurses stated that they were attending lectures and thus could not be supervised in the clinical setting. A total of 3 (n=148:2.1%) of the latter category indicated that the nurse eudcators had performed clinical assessments with students and 5 (n=148:3.6%) stated that nurse educators had attended meetings or had a heavy workload. Only 2 (n=148:1.4%) indicated that nurse educators had insufficient time to attend to nursing students and pupil enrolled nurses in the clinical setting, while 1 (n=148:0.7%) indicated that these mentees were treated as part of workforce because of staff shortages (7;n=148:5%). Nursing students and pupil enrolled nurses stated that nurse educators were on leave (3;n=148:2.1%), were attending courses (1;n=148:0.7%) or had administrative tasks to perform (10;n=148:6.4%). A small percentage (6;n=148:4.3%) of the nursing students and pupil enrolled nurses reported being allocated to work night duty and 11 (n=148:7.1%) of the latter category were on maternity leave.

For February 2011, a total of 55 (n=148:36.9%) nursing students and pupil enrolled nurses reported having received lectures and thus had not been supervised in the clinical learning environment. Only 4 (n=148:2.8%) of the nursing students and pupil enrolled nurses indicated that the nurse educators had assessed students in the clinical setting and 12 (n=148:7.8%) stated that nurse educators had to attend meetings or experienced a heavy workload (2;n=148:1.4%). One respondent (n=148:0.7%) indicated that nurse educators had insufficient time and could not attend to nursing students and pupil enrolled nurses in the clinical setting, while 4 (n=148:2.8%) stated that they were treated as part of the workforce because of staff shortages (9;n=148:6.4%).

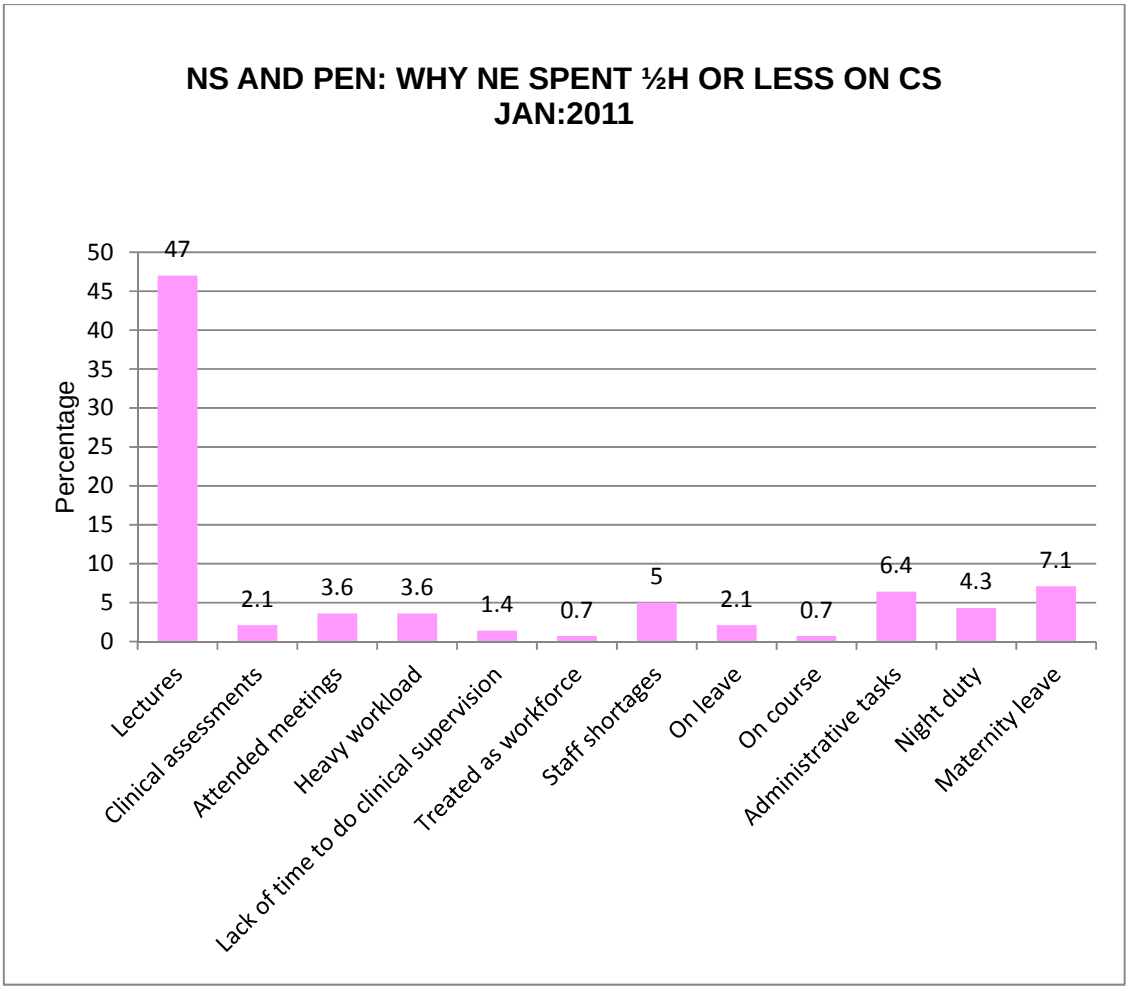

Figure 4.13: Responses of nursing students (NS) and pupil enrolled nurses (PEN) to why they think nurse educators (NE) spent half an hour or no time with them in the clinical learning environment during January 2011 (CLE) (Section B: Question 5: NS/PEN)

Nursing students and pupil enrolled nurses indicated that a few of the nurse educators were on leave (1;n=148:0.7%), attended courses (1;n=148:0.7%) or had to perform administrative tasks (13;n=148:8.5%). A total of 6 (n=148:4.3%) of the nursing students and pupil enrolled nurses were allocated to night duty while 2 (n=148:1.4%) of the latter category indicated that they were on maternity leave. Nurse educators (2;n=148:1.4%) tended not supervise nursing students and pupil enrolled nurses when there is no inquisitiveness in the clinical setting. It was also cited that when nurse educators (1;n=148:0.7%) were busy preparing their lectures for the next scheduled theoretical

block period they did not have any time to spend with nursing students and pupil enrolled nurses in the clinical learning environment.

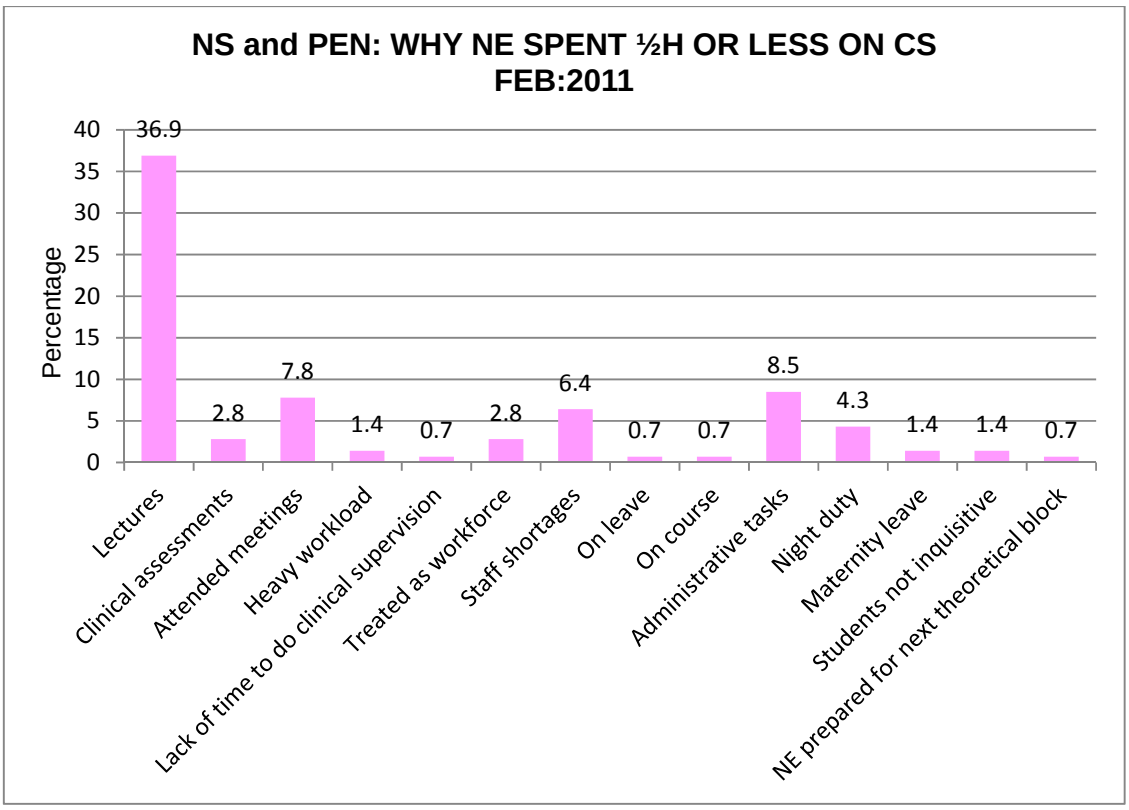

Figure 4.14: Responses of nursing students (NS) and pupil enrolled nurses (PEN) to why they think nurse educators (NE) spent half an hour or no time with them in the clinical learning environment (CLE) during February 2011 (Section B: Question 5: NS/PEN)

For March 2011, 75 (n=148:50.4%) nursing students and pupil enrolled nurses were attending a theoretical block period and were receiving lectures implying that they were not supervised in the clinical setting. A total of 3 (n=148:2.1%) of the nursing students and pupil enrolled nurses stated that the nurse educators had performed clinical assessments and 4 (n=148:2.8%) needed to attend meetings or experienced a heavy workload (1;n=148:0.7%) in the clinical setting. Only 2 (n=148:1.4%) of the nurse educators did not have time to attend to nursing students and pupil enrolled nurses in the clinical learning environment and 2 (n=148:1.4%) from the latter category stated that they were treated as part of the workforce because of staff shortages (3;n=148:2.1%). Nursing students and pupil enrolled nurses revealed that a number of the nurse

educators were on leave (1;n=148:0.7%), were attending courses (1;n=148:0.7%) or had to attend to administrative tasks (5;n=148:3.4%). One person (n=148:0.7%) from the nursing students and pupil enrolled group reported having worked night duty and not being inquisitive, 1 (n=148:0.7%) of them were on maternity leave and 2 (n=148:1.4%) of the nurse educators prepared their lectures for the next scheduled theoretical block period.

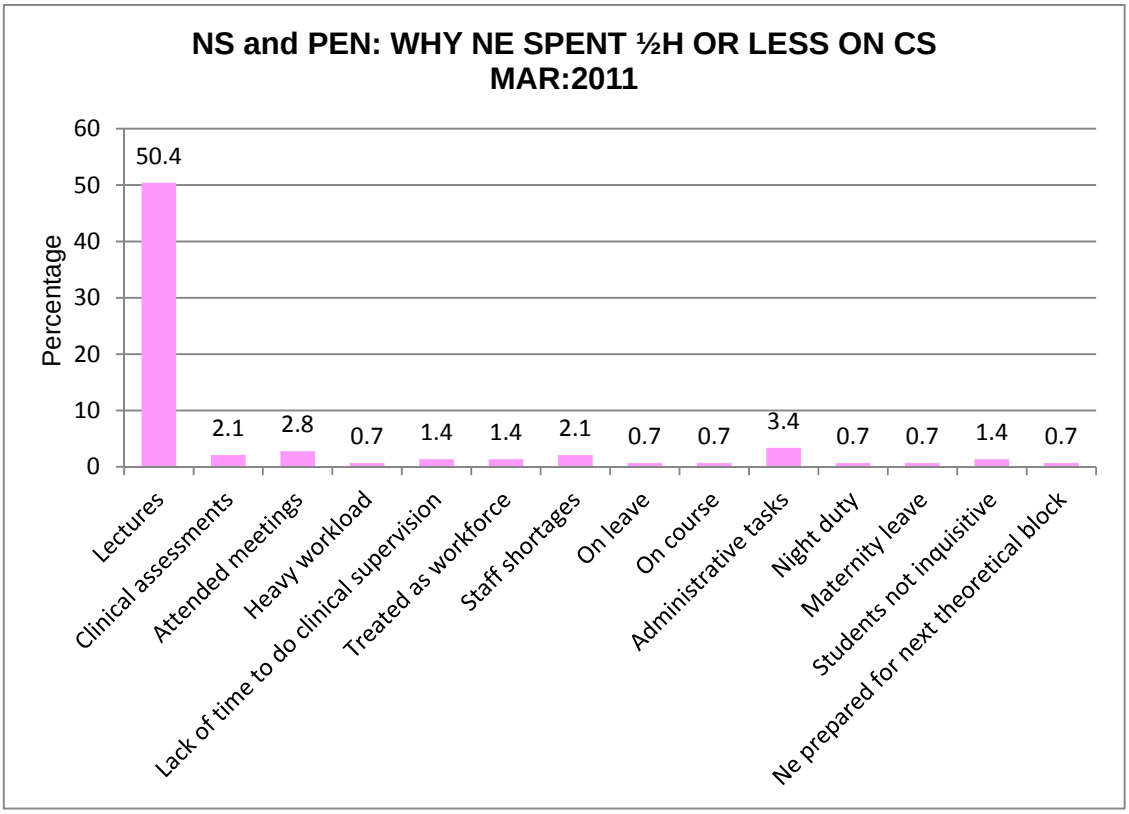

Figure 4.15: Responses of nursing students (NS) and pupil enrolled nurses (PEN) to why they think nurse educators (NE) spent half an hour or no time with them in the clinical learning environment (CLE) during March 2011 (Section B: Question 5: NS/PEN)

For April 2011, 41 (n=148:27.7%) respondents from the nursing student and pupil enrolled nurse group indicated that they had attended lectures and had not been allocated to a clinical setting. Only 3 (n=148:2.1%) of the latter category revealed that nurse educators had performed assessments with students in the clinical learning environment or had experienced a heavy workload (3;n=148:2.1%), and 5 (n=148:3.6%) of the nurse educators had reported attending meetings. A total of 4 (n=148:2.8%) from

the nursing student and pupil enrolled nurse group experienced that nurse educators had insufficient time to attend to them in the clinical setting, while 2 (n=148:1.4%) indicated that they were treated as part of workforce due to staff shortages (6;n=148:4.3%). One (n=148:0.7%) of the nurse educators was on leave (3;n=148:2.1%), attending courses (1;n=148:0.7%) or was performing administrative tasks (9;n=148:6.4%). One person (n=148:0.7%) from the nursing student and pupil enrolled nurse group reported having been allocated to work night duty and 3 (n=148:2.1%) from the latter category were on maternity leave. Nurse educators (2;n=148:1.4%) reported not having conducted clinical supervision with nursing students and pupil enrolled nurses; saying that they had merely gone to inquire on how students were doing in the clinical setting. A few of the nurse educators (2;n=148:1.4%) reported having preparing their lectures for the upcoming theoretical block period, citing this as the reason why they could not spend any time with nursing students and pupil enrolled nurses in the clinical learning environment. Furthermore 2 (n=148:1.4%) nurse educators stated that students were not inquisitive. Nursing students and pupil enrolled nurses (17;n=148:11.4%) stated that professional nurses more often attended to them in the clinical setting than did the nurse educators. One person (n=148:0.7%) from the nursing student and pupil enrolled nurse group did not offer any comment.

Figures 4.13 to 4.16 reveal that the main factor that inhibited nurse educators from facilitating the learning of nursing students and pupil enrolled nurses in the clinical setting was lecturing responsibilities. Seeing that question 2 of Section B was an open-ended question, nursing students and pupil enrolled nurses were granted the opportunity to supply more than one answer meaning that the total percentage could not add up to 100%.

Figures 4.17 to 4.20 indicate the responses of nursing students and pupil enrolled nurses to why they think professional nurses spent half an hour or no time supervising them during the months of January through to April 2011.

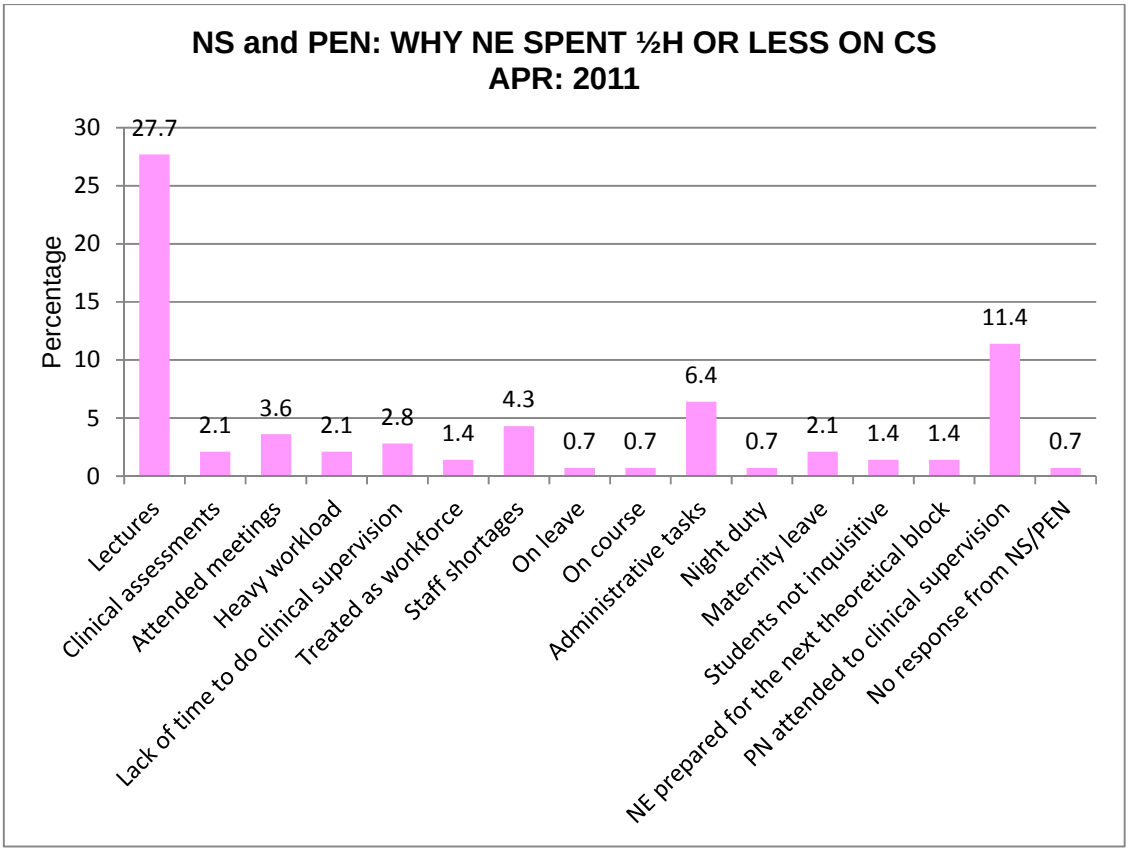

Figure 4.16: Responses of nursing students (NS) and pupil enrolled nurses (PEN) to why they think nurse educators (NE) spent half an hour or no time with them in the clinical learning environment (CLE) during April 2011 (Section B: Question 5: NS/PEN)

For January 2011, a total of 70 (n=148:47.1%) respondents from the nursing student and pupil enrolled nurse group indicated that they were attending lectures at the nursing college and thus could not be supervised in the clinical setting. A total of 4 (n=148:2.9%) from this group stated that a heavy workload prevented professional nurses from spending enough time with them in the clinical learning environment. Only 11 (n=148:7.4%) of the professional nurses indicated that they had experienced the nursing students and pupil enrolled nurses as a burden in the clinical setting, while 4 (n=148:2.9%) indicated that these mentees were treated as part of workforce due to staff shortages (2;n=148:1.5%). Nursing students and pupil enrolled nurses indicated that a few of the professional nurses had been on leave (2;n=148:1.5%) or attending courses (1;n=148:0.7%) or had administrative tasks (1;n=148:0.7%) to perform. A total of 6 (n=148:4.3%) from the nursing student and pupil enrolled nurse group were

allocated to work night duty and 1 (n=148:0.7%) of the professional nurses reported only attending to clinical supervision when students were inquisitive. One of the respondents (1;n=148:0.7%) did not provide any answer to the question posed.

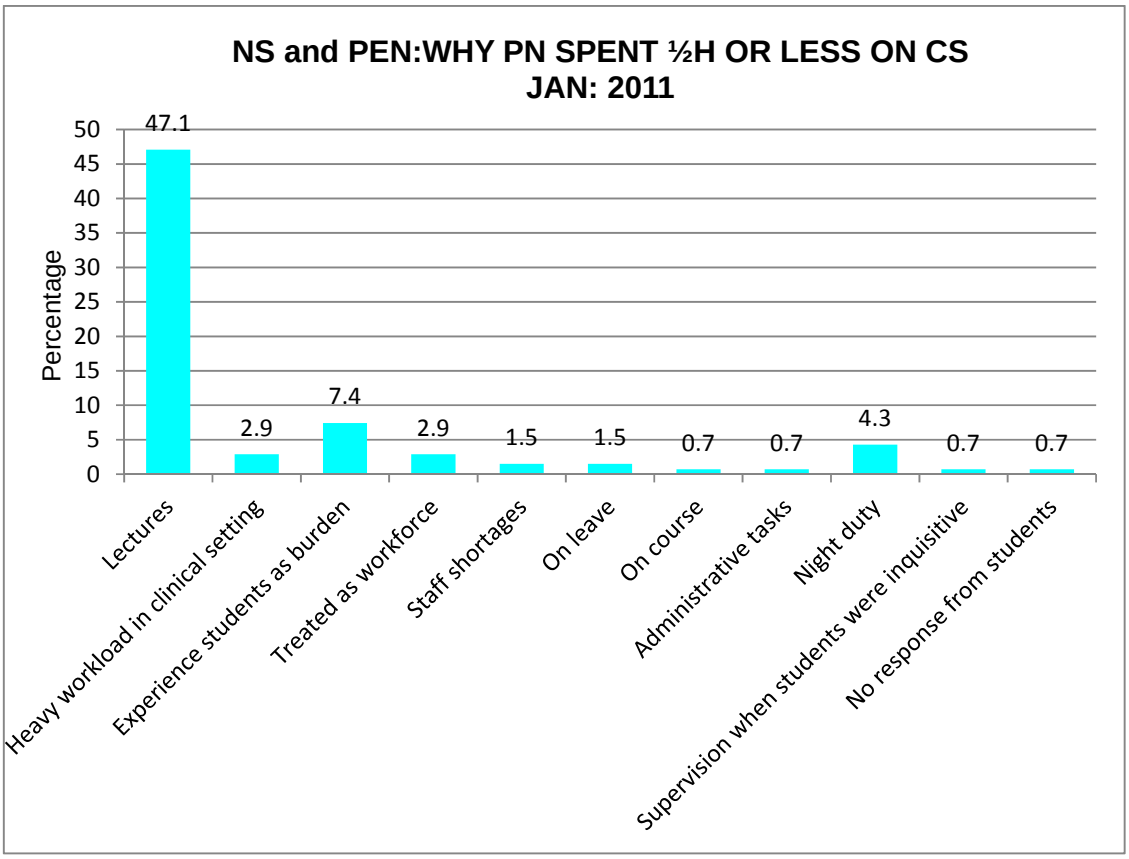

Figure 4.17: Responses of nursing students (NS) and pupil enrolled nurses (PEN) with regard to the factors influencing the time professional nurses (PN) spent with them in the clinical learning environment (CLE) during January 2011 (Section B: Question 6: NS/PEN)

For February 2011, 59 (n=148:40%) respondents from the nursing student and pupil enrolled nurse group reported having attended lectures as scheduled for them at the nursing college and had thus not been supervised in the clinical setting. Only 8 (n=148:5.2%) of the nursing students and pupil enrolled nurses stated that a heavy workload in the clinical setting inhibited professional nurses from spending enough time with them. A total of 35 (n=148:3.7%) of the nursing students and pupil enrolled nurses stated that professional nurses experienced them as a burden in the clinical setting, while 1 (n=148:0.7%) indicated that they were treated as part of the workforce due to

staff shortages (2;n=148;1.5%). One of the nursing student and pupil enrolled nurse group (1;n=148:0.7%) revealed that professional nurses had attended courses or performed administrative tasks (7;n=148:4.4%). Nursing students and pupil enrolled nurses who were allocated to work night duty came to a total of 1 (n=148:0.7%), while 1 (n=148:0.7%) of the nursing student and pupil enrolled nurse group indicated that they had been supervised by enrolled nurses in the clinical learning environment. One professional nurse (1: n=118:0.7%) reported having had to attend meetings and thus could not attend to the clinical supervision of nursing students and pupil enrolled nurses.

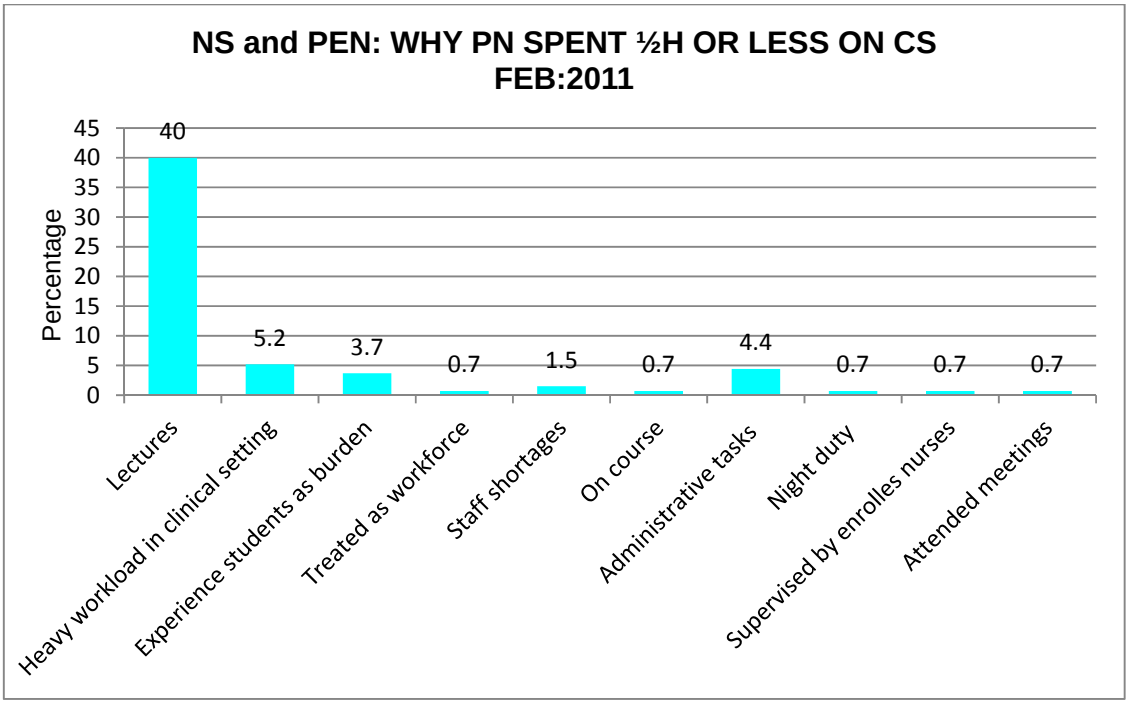

Figure 4.18: Responses of nursing students (NS) and pupil enrolled nurses (PEN) with regard to the factors influencing the time that professional nurses (PN) spent with them in the clinical learning environment (CLE) during February 2011 (Section B: Question 6: NS/PEN)

For March 2011, a total of 78 (n=148:52.9%) respondents from the nursing student and pupil enrolled nurse group reported having attended lectures at the nursing college and thus had not been exposed to clinical supervision. A total of 4 (n=148:2.9%) respondents from this same group indicated that a heavy workload in the clinical setting had inhibited professional nurses from spending time supervising them. Only 9 (n=148:5.9%) of the nursing students and pupil enrolled nurses revealed that the

professional nurses saw them as a burden in the clinical learning environment, and 2 (n=148:1.5%) stated that they were treated as part of the workforce due to staff shortages (4;n=148:2.9%). Nursing students and pupil enrolled nurses indicated that a few of the professional nurses had been attending courses (1;n=148:0.7%), were on leave (1;n=148:0.7%) or had performed additional administrative tasks (1;n=148:0.7%). According to the nursing students and pupil enrolled nurses (1;n=148:0.7%), some of the professional nurses had preferred to provide in-service training in the clinical setting and that this activity had thus replaced clinical supervision.

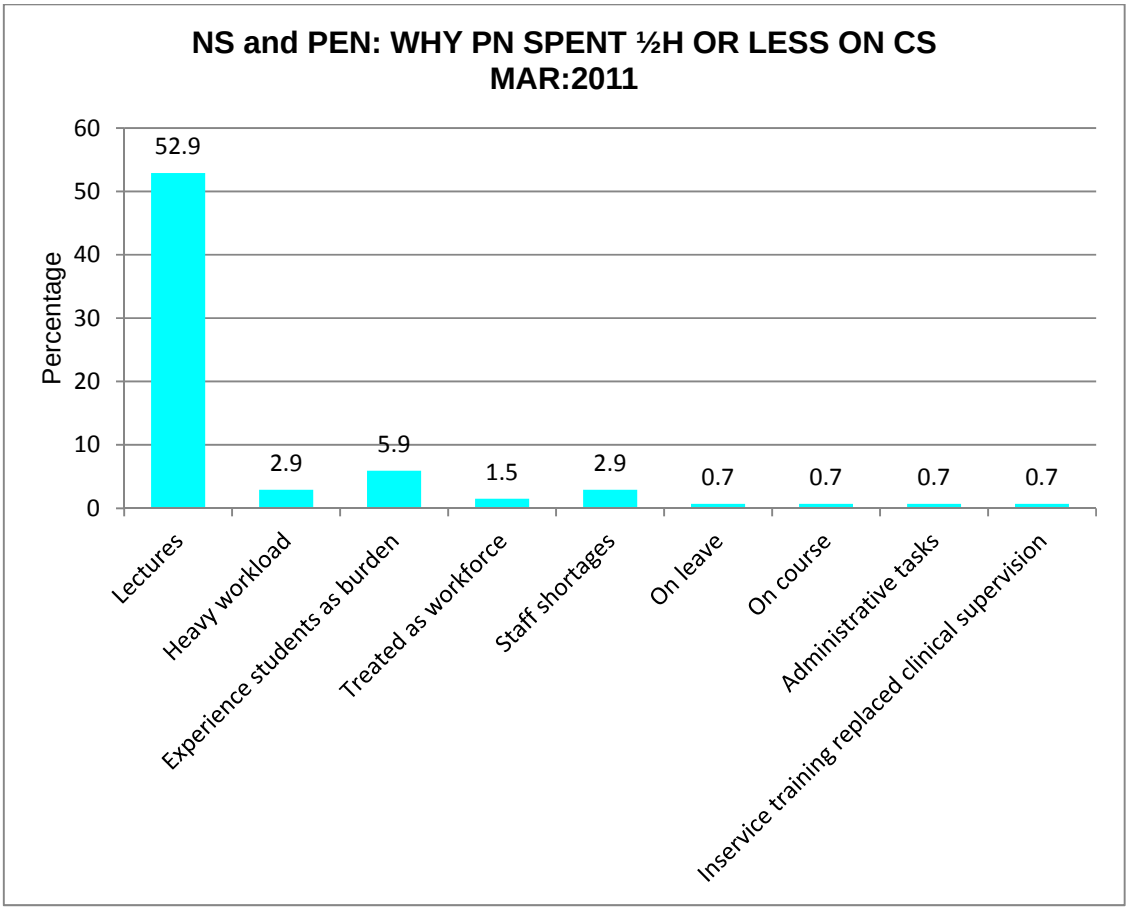

Figure 4.19: Responses of nursing students (NS) and pupil enrolled nurses (PEN) with regard to the factors influencing the time professional nurses (PN) spent with them in the clinical learning environment (CLE) during March 2011 (Section B: Question 6: NS/PEN)

For April 2011, 41 (n=148:27.9%) of the nursing students and pupil enrolled nurses reported having attended lectures at the nursing college and thus had not been

exposed to clinical supervision in the SAMHS. A total of 3 (n=148:2.2%) of the nursing students and pupil enrolled nurses indicated that a heavy workload had been experienced in the clinical setting thus preventing professional nurses from spending time with them in clinical supervision. A total of 9 (n=148:5.9%) of the nursing students and pupil enrolled nurses stated that professional nurses experienced them as a burden in the clinical learning environment. Only 1 (n=148:0.7%) respondent from the nursing student and pupil enrolled nurse group revealed that staff shortages were the main cause for not receiving any clinical supervision. Nursing students and pupil enrolled nurses stated that professional nurses had been attending courses (1;n=148:0.7%), were on leave (4;n=148:2.9%) or had performed administrative tasks (4;n=148:2.9%). One respondent (n=148:0.7%) of the nursing student and pupil enrolled nurse group revealed that professional nurses had been performing clinical assessments, that students had been were on maternity leave or that they were not sure why no attention was given to clinical supervision.

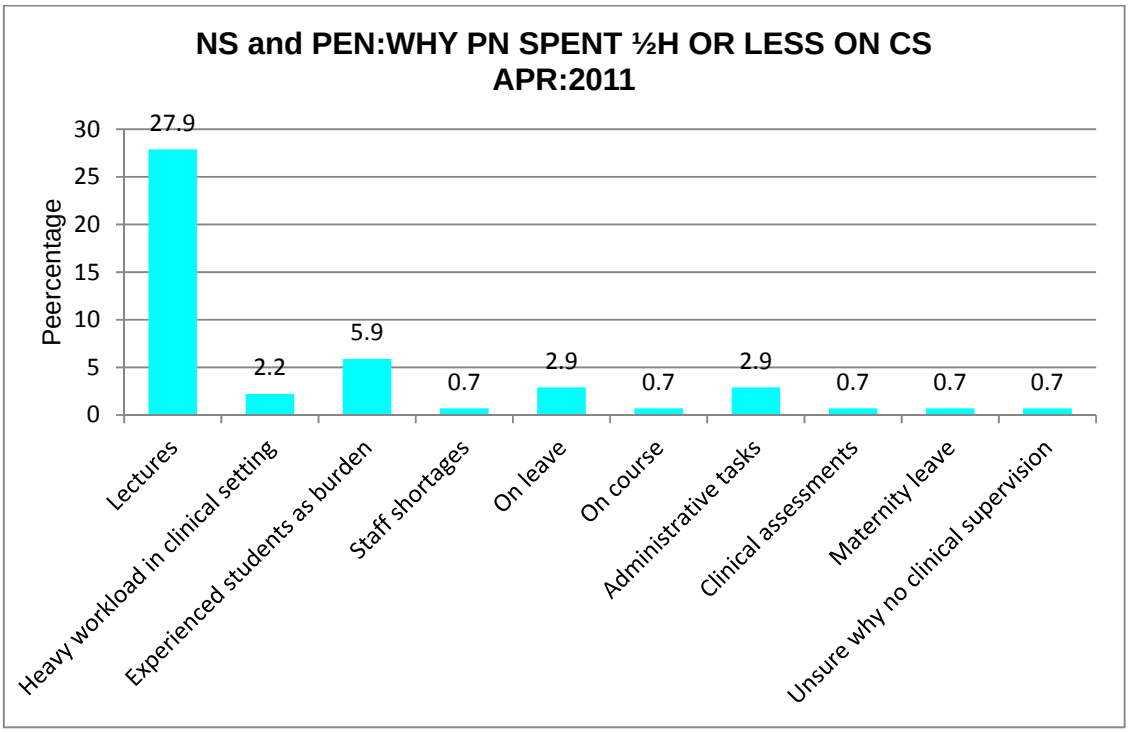

Figure 4.20: Responses of nursing students (NS) and pupil enrolled nurses (PEN) with regard to the factors influencing the time professional nurses (PN) spent with them in the clinical learning environment (CLE) during April 2011 (Section B: Question 6: NS/PEN)

Figures 4.17 to 4.20 reveal that the most important factor preventing professional nurses from supervising nursing students and pupil enrolled nurses in the clinical setting was the lecturing of students by nurse educators in the classroom.
Figure 4.21 depicts the factors influencing the time that nurse educators and professional nurses spent with nursing students in clinical supervision.

A total of 34 (n=136:25%) of the nurse educators and professional nurses revealed that a heavy workload eroded the number of opportunities to spend time with nursing students in the clinical setting. Only 24 (n=136:17.9%) of the respondents reported having attended to nursing students in the clinical learning environment when they were inquisative while 22 (n=136:16.1%) indicated that they provided in-service training to students who had been allocated to their departments. According to the nurse educators and professional nurses (2;n=136:1.8%) administrative tasks prevented them from attending to nursing students in the clinical setting. A total of 44 (n=136:32.1%) reported that staff shortages prevented them from paying any attention to clinical supervision, while 5 (n=136:3.4%) of the nurse educators and professional nurses said that they had provided nursing students with the necessary support while these students had been allocated to their clinical setting. Only 12 (n=136:8.9%) of the nurse educators and professional nurses revealed that nursing students had been supported by other nursing categories such as enrolled nurses. Furthermore 2 (n=136:1.8%) of the nurse educators and professional nurses reported not being interested in the facilitation of clinical supervison and 5 (n=136:3.6%) admitted that they had a negative attitude towards nursing students. A total of 7 (n=136:5.4%) of the nurse educators and professional nurses were on leave or had attended courses during the stipulated period and 2 (n=136:1.8%) claimed that they experienced a language problem when communicating with nursing students. Only 5 (n=136:3.6%) of the nurse educators and professional nurses said that several meetings and the ratio between the latter category and nursing students prevented them from facilitating clinical supervision. The nurse educators and professional nurses that admitted who admitted nursing students were used as part of the workforce in the clinical setting and could therefore not receive any clinical supervision came to a total of 5 (n=136:3.6%). Two (n=136:1.8%) nurse

educators and professional nurses reported being unsure as to why they did not attend to clinical supervision.

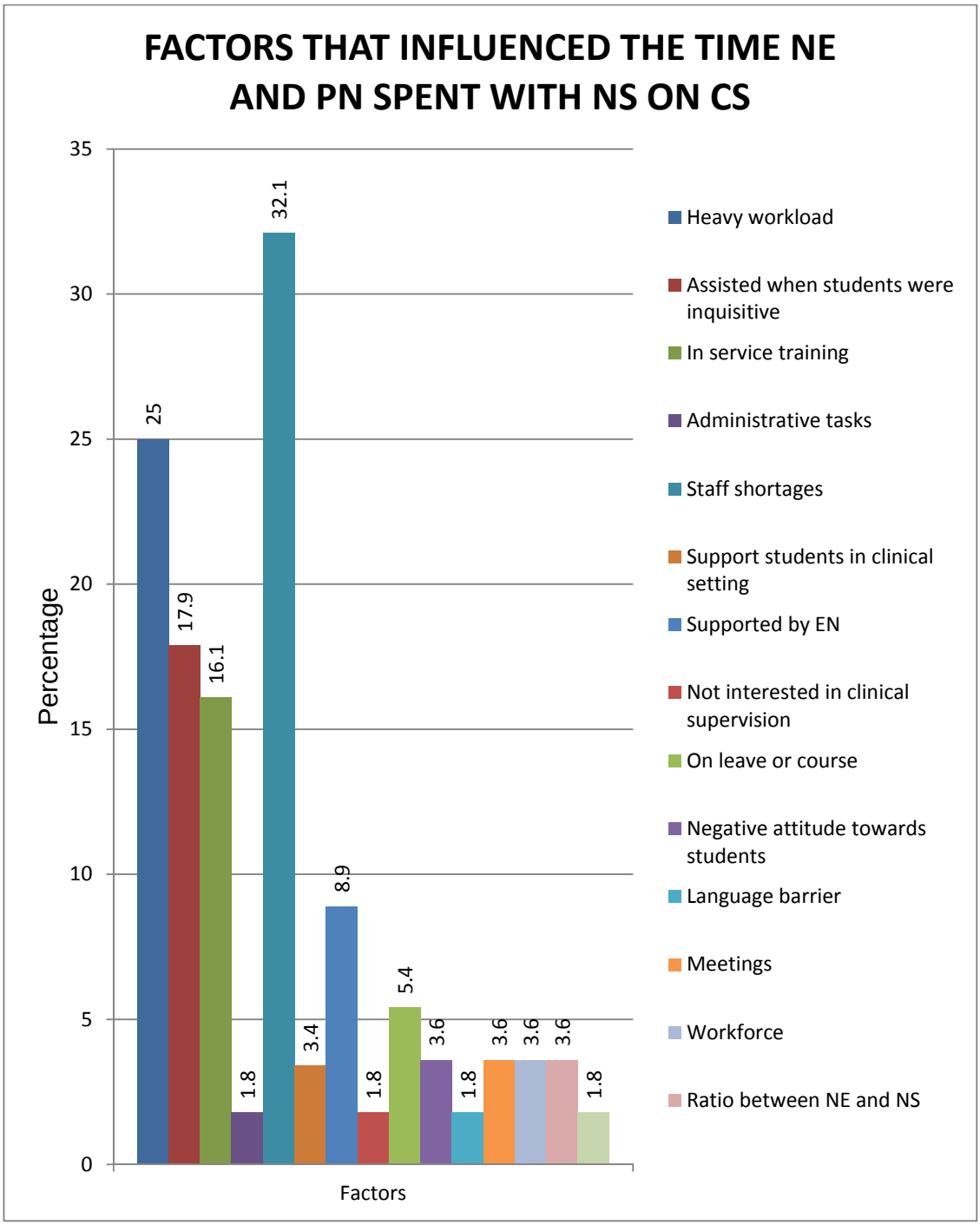

Figure 4.21: Factors influencing the time nurse educators (NE) and professional nurses (PN) spent with nursing students (NS) on clinical supervision (CS) (Section B: Question 6: NE/PN)

Figure 4.21 reveals that the two most significant factors that prevented nurse educators and professional nurses from supervising nursing students in the clinical setting constituted a heavy workload (34;n=136:25%) and staff shortages (44;n=136:32.1%).

Figure 4.22 gives an indication of the responses of nurse educators and professional nurses with regard to the factors influencing the time that they spent with pupil enrolled nurses in the clinical setting. A total of 44 (n=136:32.5%) of the nurse educators and professional nurses revealed that a heavy workload and staff shortages (15:n=136:11.3%) in the clinical setting influenced the amount of time that they spent with pupil enrolled nurses in the clinical setting.

When pupil enrolled nurses were more inquisitive and willing to assist with the nursing care of patients, nurse educators and professional nurses (14;n=136:10%) tended to give them more attention in the clinical setting. It sometimes happened that pupil enrolled nurses were moved to another department (3;n=136:2.5%) to help with the heavy workload and thus would not receive any clinical supervision for the day. Only 24 (n=136:17.5%) of the nurse educators and professional nurses indicated that they spent time supervising pupil enrolled nurses only during orientation and whilst providing on-the-spot training while 5 (n=136:3.8%) respondents revealed that they did not have time to spend with them, worked night duty, or were not interested in facilitating clinical supervision.

A total of 5 (n=136:3.8) of the nurse educators and professional nurses said that they had spent time with pupil enrolled nurses when they had to explain patients' diagnoses in the specific clinical department and that it depended on how competent the pupil enrolled nurses were. Some of the respondents (17;n=136:12.5%) who completed the questionnaires were still undergraduates at the time of the survey and thus could not spend any time with pupil enrolled nurses in the clinical setting. A total of 5 (n=118:3.8%) of the professional nurses revealed that pupil enrolled nurses had not been allocated to their departments during the time of the survey or that they had not been interested to learn more about the nursing profession. Furthermore 3

(n=118:2.5%) indicated that they simply did not have time to spend supervising pupil enrolled nurses on especially when quite a number of them had been allocated to the same department.

A total of 5 (n=118:5%) of the professional nurses stated that they trained pupil enrolled nurses on the spot according to their level of knowledge (3;n=118:2.5%). When the equipment was available in the clinical departments, professional nurses (2;n=118:1.3%) reported having been willing to attend to pupil enrolled nurses in the clinical setting. Only 2 (n=136:1.3%) of the nurse educators and professional nurses reported having attending courses during the time of the survey and 2 (n=136:1.3%) indicated that they had provided in-service training to pupil enrolled nurses and thus had not facilitated clinical supervision. A total of 2 (n=118:1.3%) of the professional nurses stated that pupil enrolled nurses had spent a lot of time at the training institution and thus could not attend to clinical supervision. Nurse educators and professional nurses (4;n=136:2.5%) felt that they had provided adequate support to pupil enrolled nurses in the clinical setting and 2 (n=136:1.3%) said that too many pupil enrolled nurses were simultaneously allocated to the same department, making it difficult to supervise them all.

Figure 4.22 reveals that the most significant factors that influenced the time that nurse educators and professional nurses spent on clinical supervision constituted a heavy workload in clinical departments (44;n=136:32.5%), orientation of students (24;n=136:17.5%) and the fact that some of the professional nurses were still students themselves (17;n=136:12.5%) at the time of the survey.

Figure 4.23 shows the responses of nurse educators (n=18) and professional nurses (n=118) on which category should be responsible for the clinical supervision of nursing students (n=104) and pupil enrolled nurses (n=44) in the clinical setting.

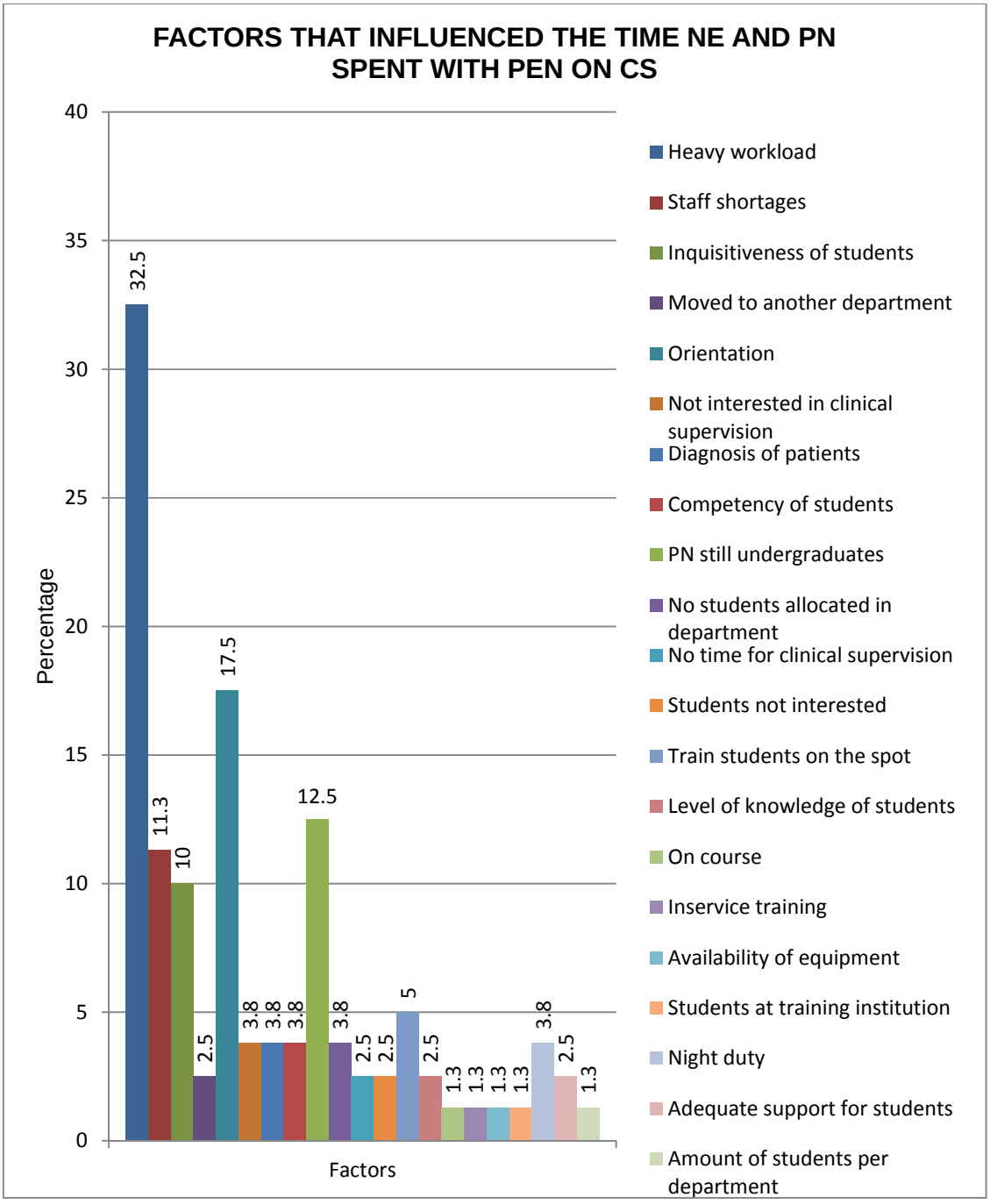

Figure 4.22: Factors influencing the time nurse educators (NE) and professional nurses (PN) spent with pupil enrolled nurses (PEN) in clinical supervision (CS) (Section C: Question 3)

Concerning nursing students, the vast majority of 11 (n=18:62.5%) nurse educators agreed that both nurse educators and professional nurses had a training function and were responsible for supervision in the clinical learning environment. Only 5

(n=18:25%) of the respondents preferred preceptors and mentors to perform clinical supervision in the SAMHS. A total of 2 (n=18:8.9%) of the nurse educators felt that it is the responsibility of the nurse educators to attend to clinical supervision while 1 respondent (n=18:3.6%) believed it to be the task of professional nurses.

A total of 90 (n=118:76.1%) of the professional nurses indicated that the responsibility is laid upon them to attend to pupil enrolled nurses in the clinical setting as clearly stipulated by Regulation R425 of the SANC. Only 16 (n=118:13.8%) preferred preceptors and mentors to assume responsibility for the pupil enrolled nurses, while 7 (n=118:6.3%) recommended it to be the task of nurse educators. A few of the professional nurses (4;n=118:3.8%) believed it is the responsibility of professional nurses to guide pupil enrolled nurses in the clinical setting.

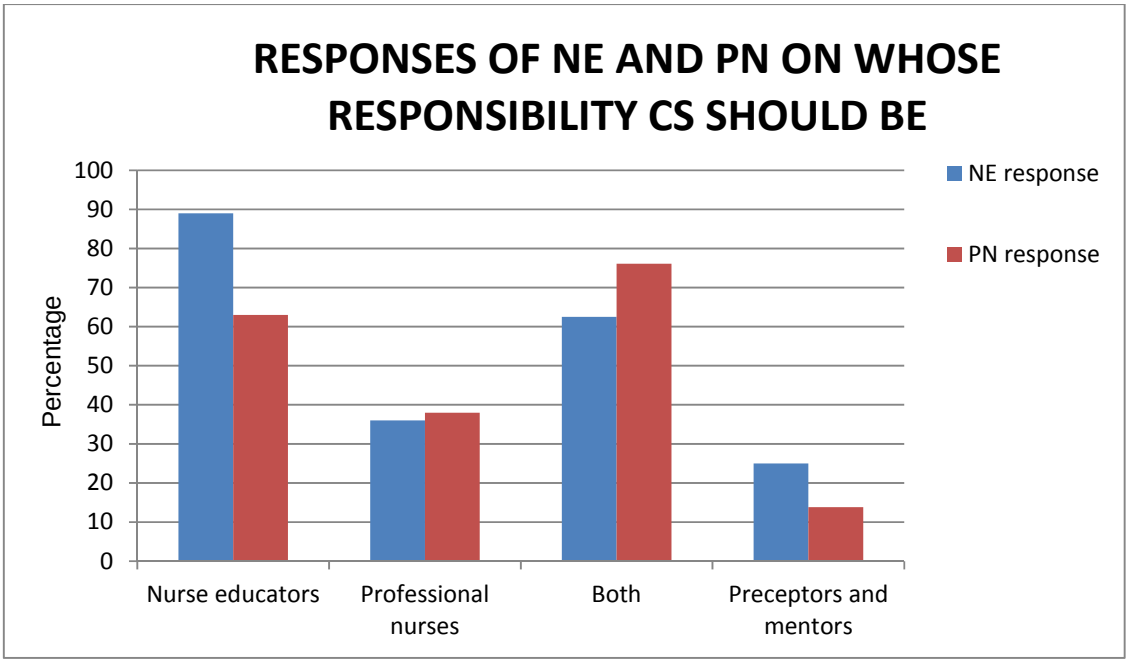

Figure 4.23: Responses of nurse educators (NE) and professional nurses (PN) with regard to their responsibility for clinical supervision (CS) of nursing students (NS) and pupil enrolled nurses (PEN) (Section B: Question 3: NE/PN and Section C: Question 4: NE/PN)

Figure 4.24 depicts the responses of nurse educators and professional nurses (n=136) with regard to the nursing category they feel should be resonsible for the clinical supervision of nursing students.

Only 12 (n=136:8.9%) of the respondents indicated that nurse educators made use of old methods when demonstrating procedures in the clinical setting, because they were not knowledgeable with regard to the latest techniques and methods used in the field. A total of 10 (n=136:7.1%) respondents said that nurse educators were not theatre-trained and thus could not supervise nursing students in the operating theatre. The vast majority of 83 (n=136:60.7%) of the respondents agreed that nurse educators and professional nurses had the responsibility to facilitate learning in the clinical setting and 10 (n=136:7.1%) indicated that when both categories were involved better health services could be rendered. Only 10 (n=136:7.1%) were of the opinion that nurse educators were not readily available in the clinical setting unlike professional nurses. A total of 7 (n=136:5.4%) agreed that a mentor needs to be appointed for clinical supervision while 2 (n=136:1.8%) of the respondents stated that nurse educators should be more visible in the clinical setting.

According to the respondents (7;n=136:5.4%), professional nurses were present in the clinical setting around the clock, while nurse educators were not. Nurse educators (5; n=136:3.6%) were only seen in practice when performing assessments. A few (2;n=136:1.8%) of the respondents indicated that nurse educators were more knowledgeable on the clinical outcomes of nursing students and should therefore be responsible for clinical supervision. When the workload in the clinical learning environment was found to be too heavy, students did not receive any clinical supervision. The majority of respondents revealed that when there was a heavy workload neither the professional nurse nor the nurse educators paid attention to clinical supervision. A total of 5 (7;n=136:5.4%) of the respondents suggested that time needed to be put aside for clinical supervision by both nursing categories.

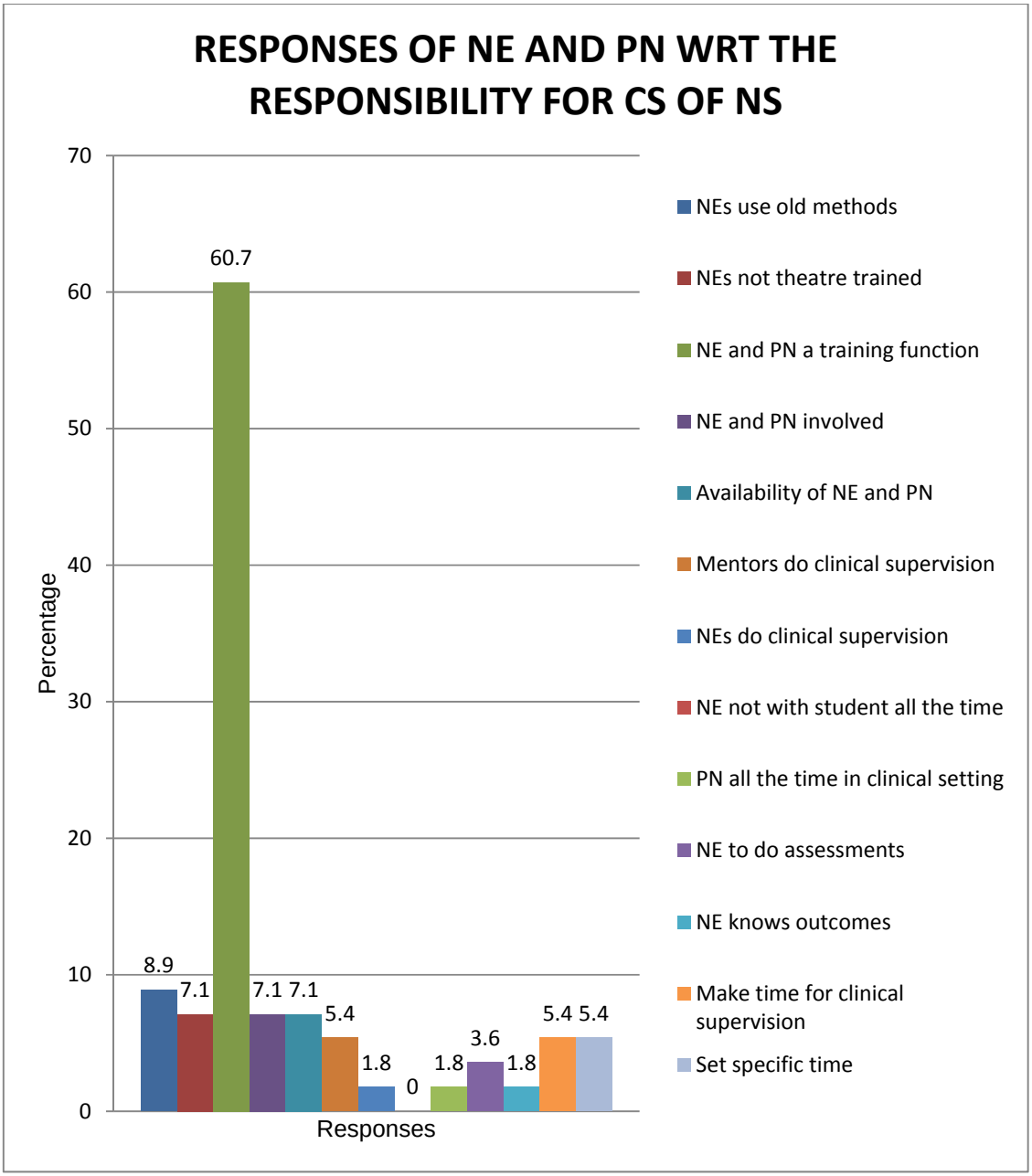

Figure 4.24: Responses of nurse educators and professional nurses with regard to the responsibility for clinical supervision (CS) of nursing students (Section B: Question 4: NE/PN and Section C: Question 5: NE/PN)

Figure 4.25 gives an indication of the responses of nurse educators and professional nurses with regard to the nursing category which should be responsible for the clinical supervision of pupil enrolled nurses.

According to 9 (n=136:6.3%) of the respondents, it is the responsibility of the nurse educator to attend to the clinical supervision of pupil enrolled nurses. Only 7 (n=136:5%) of the nurse educators and professional nurses stated that they regarded clinical supervision as the responsibility of the professional nurse due to their availability in the clinical learning environment. A total of 83 (n=136:61.3%) indicated that nurse educators and professional nurses had a teaching function and therefore both categories needed to supervise pupil enrolled nurses in practice.

Only 3 (n=136:2.5%) of the respondents revealed that nurse educators had a heavy workload and found it difficult to attend to pupil enrolled nurses in the clinical setting. A total of 9 (n=136:6.3%) stated that they would prefer mentors or preceptors to be appointed to take responsibility for the clinical supervision of pupil enrolled nurses. A few of the respondents (7;n=136:5%) who took part in the survey said that professional nurses found it difficult to supervise pupil enrolled nurses due to the fact that they had to attend to patients and were given additional administrative tasks (5;n=136:3.8%). Only 2 (n=136:1.3%) respondents revealed that better health services could be rendered if both nurse educators and professional nurses were involved with clinical supervision.

A total of 2 (n=136:1.3%) respondents stated that mentors needed to take the responsibility for clinical supervision and attend to students on a daily basis because nurse educators did not have sufficient time to be in the clinical learning environment all the time (7: n=136:5%). It was felt that professional nurses (3;n=136:2.5%) could spend more time with pupil enrolled nurses because they were in the clinical setting around the clock.

Only 2 (n=136:1.3%) respondents indicated that nurse educators were to take responsibility for the clinical supervision of pupil enrolled nurses due to the fact that they were better acquainted with the learning outcomes. A few (9;n=136:6.3%) of the respondents indicated that nurse educators only performed assessments with pupil enrolled nurses and that professional nurses (2;n=136:1.3%) were mainly responsible for supervision in the clinical learning environment. A total of 3 (n=136:2.5%) of the

respondents stated that clinical supervision of pupil enrolled nurses put additional strain on professional nurses.

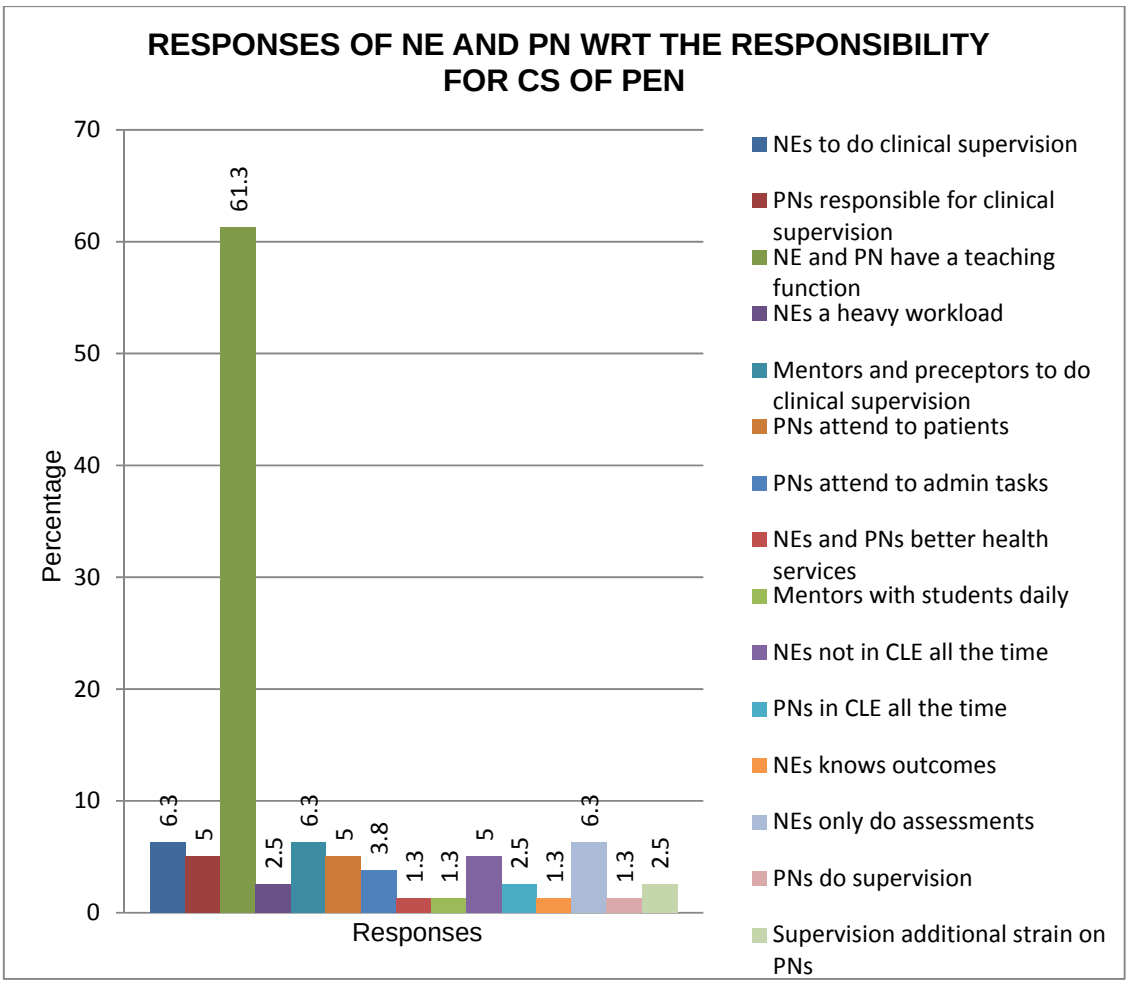

Figure 4.25: Responses of nurse educators (NE) and professional nurses (PN) with regard to the responsibility for clinical supervision (CS) of pupil enrolled nurses (PEN) (Section C: Question 5: NE/PN)

Figure 4.26 depicts the suggestions that nurse educators and professional nurses have with regard to the clinical supervision of nursing students.

A total of 34 (n=136:25%) of the nurse educators and professional nurses agreed that both categories had to take responsibility for the clinical supervision of nursing students and that this should take place on a daily basis (24:n=136:17.9%). It was felt that nursing students had to be motivated (22:n=136:16.1%) when allocated to the clinical

setting. Furthermore it was felt that the appointment of mentors and preceptors (2:n=136:1.8%) in the clinical setting would enhance clinical supervision in the SAMHS. Only 44 (n=136:32.1%) of the nurse educators and professional nurses indicated that staff shortages in the clinical setting needed to be rectified before more attention could be paid to nursing students when allocated to the clinical learning environment.

A total of 5 (n=136:3.4%) of the nurse educators and professional nurses said that they continued with on-the-spot teaching and utilised teachable moments with nursing students. Furthermore, these respondents reported that nursing students should get the opportunity to demonstrate clinical skills to their peers (12;n=136:8.9%) under the supervision of nurse educators and professional nurses, and that the establishment of a clinical department (2;n=136:1.8%) in all military hospitals would enhance the facilitation of clinical supervision. A few (7;n=136:5.4%) of the nurse educators and professional nurses revealed that clinical placements of nursing students needed thorough planning to prevent overcrowding in one area of specialisation. It was also revealed that the clinical supervision of nursing students should preferably be conducted by nurse educators (5;n=136:3.6%) to ensure quality patient care and to train professional nurses of a high standard. Clinical meetings between the personnel of the training institution and the professional nurses in practice should take place on a regular basis to enhance clinical supervision of nursing students. A total of 5 (n=136:3.6%) of the nurse educators and professional nurses indicated that students had to receive in-service training before being allocated to the clinical setting and that they should be regarded as supernumerary and not as part of the workforce (5;n=136:3.6%). When recruiting novice nursing students, it was recommended that the selection panel needed to clarify whether the candidate had chosen nursing as a career or not (5;n=136:3.6%).

The research revealed that professional nurses (4;n=118:3.6%) would prefer nursing students and pupil enrolled nurses to spend longer periods of time in the clinical learning environment. Respondents (2;n=136:1.8%) suggested that nurse educators should update their knowledge on modern equipment and that they should use the latest methods in the practical environment. Nursing students and pupil enrolled nurses

should be provided with clinical workbooks with clear outcomes for each clinical department (2;n=136:1.8%). Respondents (2;n=136:1.8%) also indicated preference for uniformity in the clinical settings of all the military hospitals.

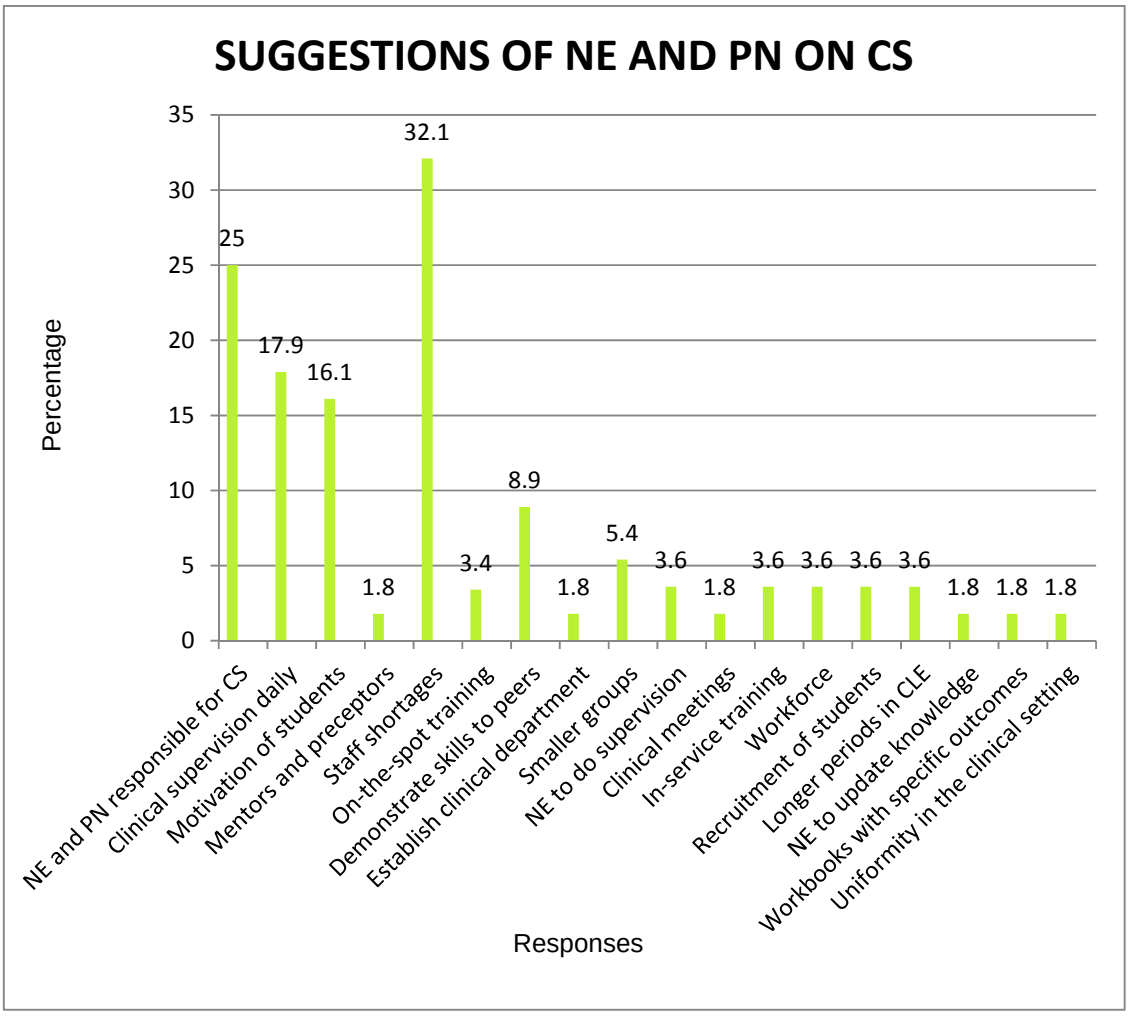

Figure 4.26: Suggestions of nurse educators (NE) and professional nurses (PN) on clinical supervision (CS) of nursing students (NS) (Section B: Question 5: NE/PN)

Figure 4.27 shows the suggestions that nurse educators and professional nurses had made with regard to the clinical supervision of pupil enrolled nurses.

A total of 49 (n=136:36.3%) of the nurse educators and professional nurses felt that nurse educators were not actively involved in the clinical supervision of students and 12 (n=136:8.8%) reported that pupil enrolled nurses needed to be orientated before they

were exposed to the clinical environment. Only 7 (n=136:5%) of the nurse educators and professional nurses said that pupil enrolled nurses were not supposed to be used as part of the workforce in the clinical setting. A total of 17 (n=136:12.5%) of the professional nurses indicated that it was the responsibility of nurse educators and professional nurses to facilitate learning in the clinical setting while 9 (n=136:6.3%) said that there was a need for clinical meetings to be held between the nurse educators in the training institution and professional nurses in the clinical setting in order to discuss students' development. A few (19;n=136:13.8%) of the nurse educators and professional nurses suggested that the appointment of a mentor would solve the problem facilitating clinical supervision in practice while 3 (n=136:2.5%) said that more nurse educators should be appointed to give the necessary attention to clinical supervision.

Only 7 (n=136:5%) of the nurse educators and professional nurses revealed that nurse educators were not exposed to the latest methods and technology in use in the clinical environment and that they needed regular in service training to raise their standards. A few of the nurse educators and professional nurses (2:n=136:1.3%) felt that pupil enrolled nurses should be supported in the clinical setting, because according to 5 (n=118:3.4%) of the professional nurses, students are taught nursing care through clinical supervision. A total of 7 (n=136:5%) of the respondents felt that professional nurses with appropriate qualifications should be responsible for clinical supervision of pupil enrolled nurses because they were involved in the nursing care of patients around the clock while nurse educators were not so readily seen in the clinical setting. Only 17 (n=136:12.5%) of the nurse educators and professional nurses said that specific outcomes needed to be available for pupil enrolled nurses in the clinical setting in order to achieve these, and 2 (n=136:1.3%) felt that guidelines should be given on how much time needed to be spent with pupil enrolled nurses.

Two professional nurses (2;n=136:1.3%) said that pupil enrolled nurses had to be allocated to specific departments for longer periods before moved to other departments. According to the professional nurses (3;n=118:2.5%), nurse educators had the

responsibility of training and guiding them in the specific outcomes that pupil enrolled nurses had to achieve in the clinical setting. Furthermore 7 (n=136:5%) said that the clinical supervision of students should take place on a daily basis. Only 3 (n=136:2.5%) of the nurse educators and professional nurses said that more attention should be given to the recruitment of pupil enrolled nurses because it sometimes happened that some of them entered the nursing profession because they could not be employed elsewhere. It was felt that this could lead to the lowering of patient care standards.

A total of 5 (n=118:3.8%) of the professional nurses said that the clinical procedures, which needed to be mastered by pupil enrolled nurses, should be practiced regularly and signed for in clinical workbooks. It was felt that the establishment of a clinical department in each of the military hospitals needed to get urgent attention (2;n=136:1.3%), in order to try and accomplish uniformity in clinical settings. Nurse educators and professional nurses (2;n=136:1.3%) felt that pupil enrolled nurses needed to be more inquisitive and that actual patients and not mannequins were to be used when assessing a procedure in the clinical setting. According to 2 (n=136:1.3%) of the nurse educators and professional nurses clinical contact sessions for pupil enrolled nurses must take place on a regular basis, preferably weekly. Professional nurses (2;n=118:1.3%) said that nurse educators must not only be visible in the clinical setting when they needed to do assessments, but they must be available for clinical supervision on a daily basis to respond to pupil enrolled nurses' questions.

4.5 SECTION D AND E: ROLES AND RESPONSIBILITIES OF NURSE EDUCATORS (NE) AND PROFESSIONAL NURSES (PN) IN THE CLINICAL SETTING

The following section gives an overview of the responses of nurse educators and professional nurses to specific statements regarding their roles and responsibilities in the clinical setting.

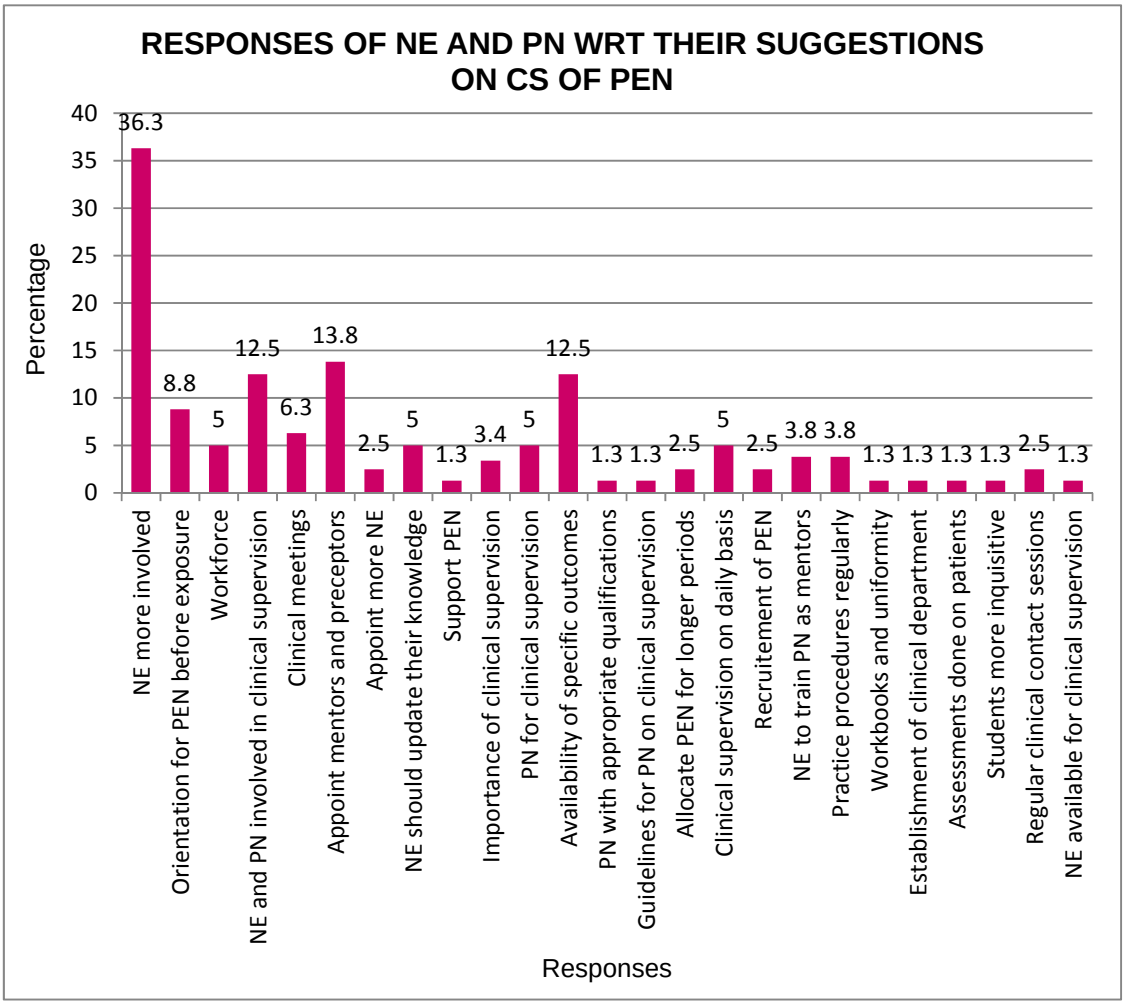

Figure 4.27: Responses of nurse educators (NE) and professional nurses (PN) with regard to their suggestions on clinical supervision (CS) of pupil enrolled nurses (PEN) (Section C: Question 6: NE/PN)

Figure 4.28 reveals the responses of nurse educators (n=18) and professional nurses (n=118) with regard to the support they provided to nursing students in the clinical setting.

A total of 6 (n=18:33.3%) of the nurse educators in the SAMHS disagreed and 3 (n=18:16.7%) strongly disagreed that clinical facilities are supportive of learning, professional growth and the development of skills, while a few (7:n=118:5.9%) of the professional nurses disagreed and 3 (n=118:2.5%) strongly disagreed with the statement. Only 5 (n=18:27.8%) of the nurse educators agreed, while 4 (n=18:22.2%)

strongly agreed that they did provide adequate support in the clinical setting. On the other hand 67 (n=118:56.8%) of the professional nurses agreed and 41 (n=118:34.8%) disagreed that adequate clinical support was provided to nursing students and pupil enrolled nurses.

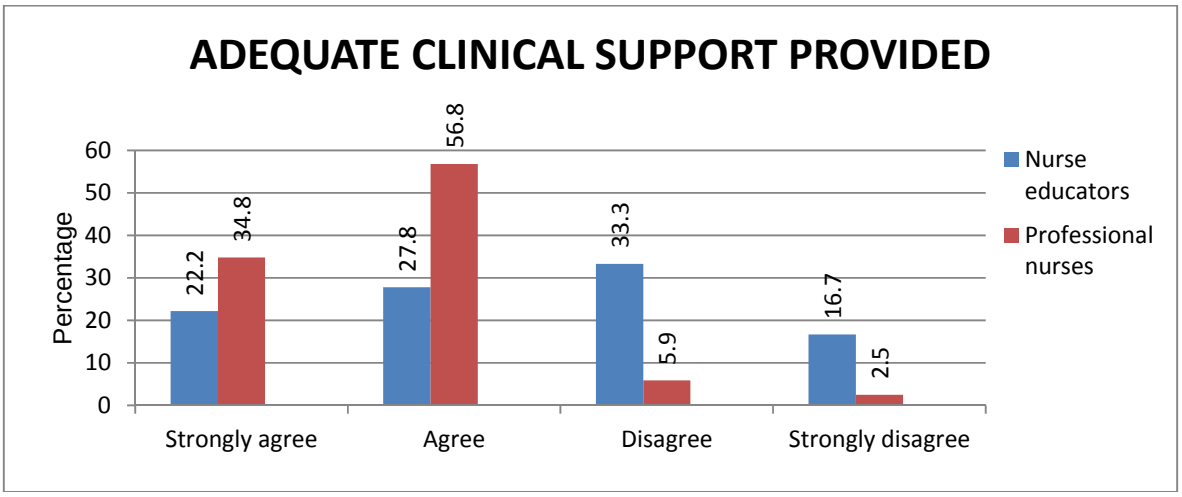

Figure 4.28: Nurse educators' (NE) and professional nurses' (PN) support to nursing students (NS) in the clinical learning environment (CLE) (Section D: Question 1.1 and Section E: Question 1.1: NE/PN)

Figure 4.29 shows that the majority of the nursing students and pupil enrolled nurses (62;n=148:41.9%) were more likely to agree that the support provided by nurse educators in the clinical setting was inadequate. A total of 37 (n=148:25%) of the nursing students and pupil enrolled nurses strongly agreed that nurse educators did not provide adequate support, while only 16 (n=148:10.8%) strongly disagreed and 33 (n=148:22.3%) disagreed with this statement.

Figure 4.30 depicts that the majority of the nurse educators (6;n=18:33.4%) agreed and 4 (n=18:22.2%) strongly agreed, while 41 (n=118:34.7%) of the professional nurses agreed and 21 (n=118:17.8%) strongly disagreed to the statement that they did not experience tension between the execution of daily routine tasks and clinical supervision. A total of 4 (n=18:22.2%) of the nurse educators disagreed and strongly disagreed, while 39 (n=118:33.1%) of the professional nurses disagreed and 17 (n=118:14.4%)

strongly disagreed to the statement that they did not experience any tension between the execution of their daily routine tasks and clinical supervision.

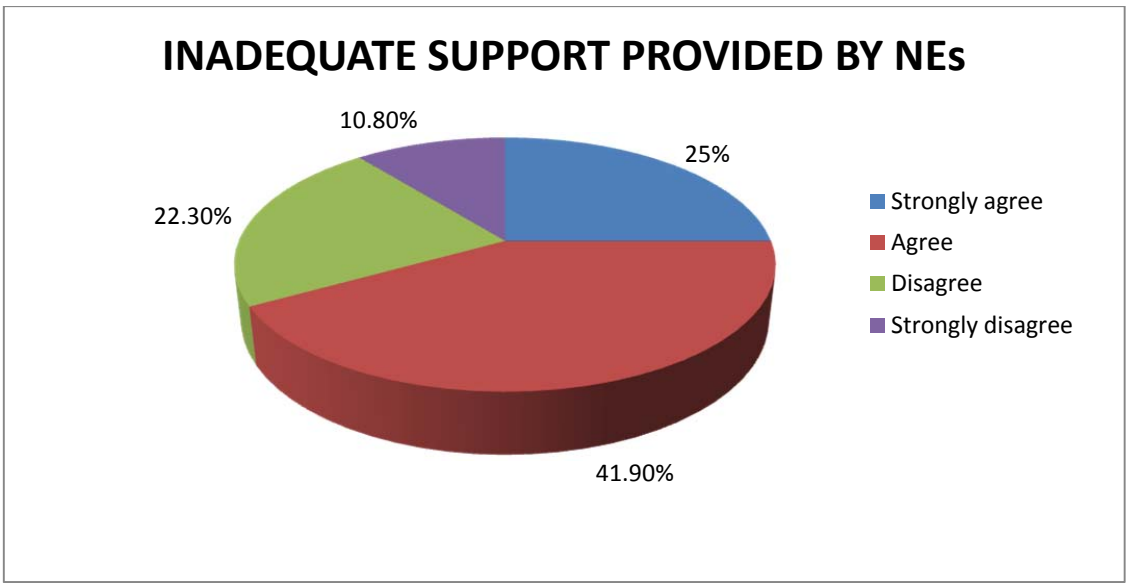

Figure 4.29: Response to statement that nurse educators (NE) provided inadequate support in the clinical learning environment (CLE) (Section C: Question 1.8: NS/PEN)

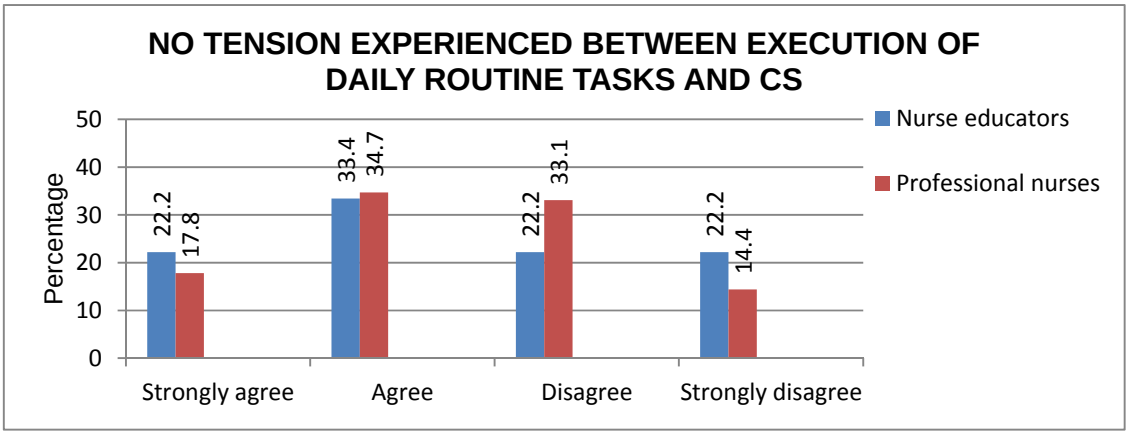

Figure 4.30: Response to statement that nurse educators (NE) and professional nurses (PN) did not experience tension between the execution of daily routine tasks and clinical supervision (CS) (Section D: Question 1.2 and Section E: Question 1.2: NE/PN)

Figure 4.31 gives an indication that the majority of the nurse educators (10; n=18:55.5%) and 40 (n=118:34%) of the professional nurses strongly agreed with the statement that they were competent to teach up-to-date clinical skills. Only 46

(n=148:31.1%) of the nursing students and pupil enrolled nurses strongly agreed that nurse educators and professional nurses had the competency to teach up-to-date clinical skills. A total of 3 (n=18:16.7%) of the nurse educators and 64 (n=118:54.2%) of the professional nurses and 61 (n=148:41.1%) of the nursing students and pupil enrolled nurses agreed that nurse educators and professional nurses in the SAMHS were competent to teach up-to-date clinical skills. The minority of nurse educators 4 (n=18:22.2%) disagreed and 1 (n=18:5.6%) strongly disagreed with the statement that they were not competent to teach up-to date clinical skills, while only 9 (n=118:7.6%) of the professional nurses disagreed and 5 (n=118:4.2%) strongly disagreed with this statement. The nursing students and pupil enrolled nurses who disagreed on the aspect totaled 35 (n=148:23.7%) and only 6 (n=148:4.1%) strongly disagreed with this statement.

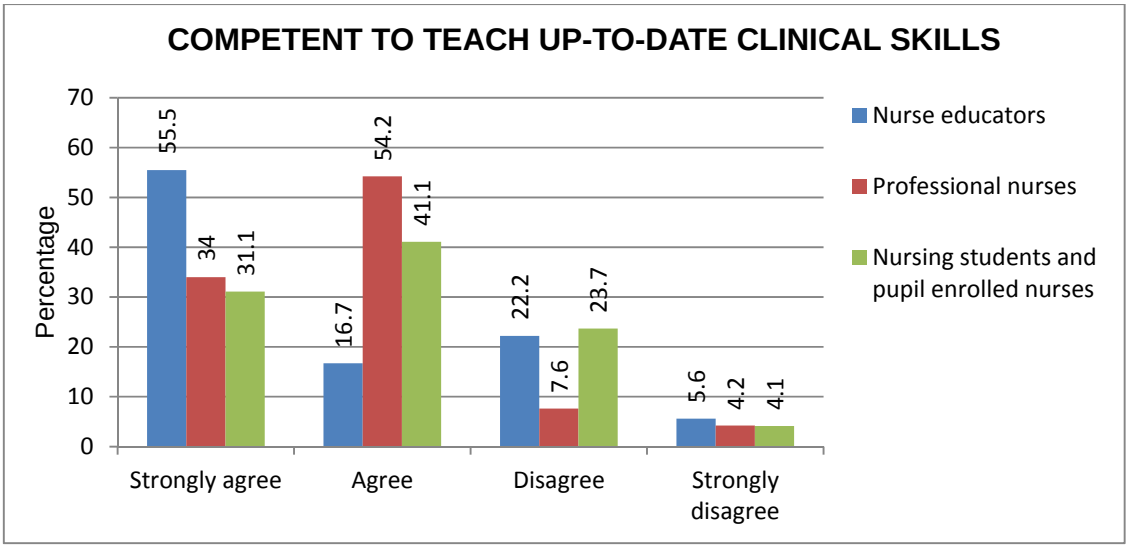

Figure 4.31: Response to statement that nurse educators (NE) and professional nurses (PN) were competent to teach up-to-date clinical skills (Section C: Question 1.4 NS/PEN and Section D: Question 1.3 and Section E: Question 1.3: NE/PN)

Figure 4.32 indicates that nurse educators (10;n=18:55.5%) and professional nurses (70;n=118:59.4%) were more likely to agree that the learning needs of nursing students and pupil enrolled nurses were met in the clinical placement areas. A total of 3 (n=18:16.7%) of the nurse educators and 25 (n=118:21.3%) of the professional nurses strongly agreed that they met their students' clinical learning needs. Only 4

(n=18:22.2%) of the nurse educators disagreed and 1 (n=18:5.6%) strongly disagreed to this statement, while 20 (n=118:16.8%) of the professional nurses disagreed and 3 (n=118:2.5%) strongly disagreed.

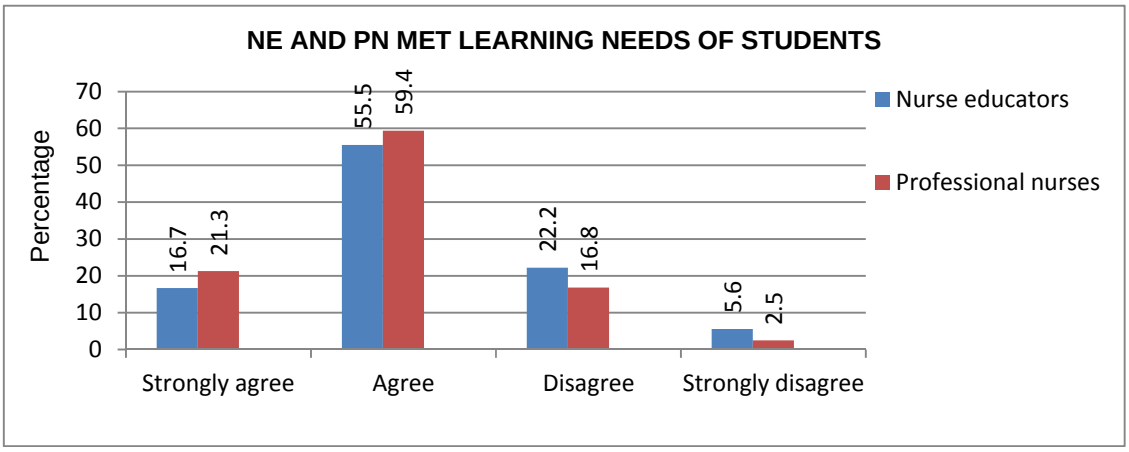

Figure 4.32: Response to statement that nurse educators (NE) and professional nurses (PN) met the learning needs of students in specific clinical placement areas (Section D: Question 1.4 and Section E: Question 1.4: NE/PN)

Figure 4.33 shows that 10 (n=18:55.5%) of the nurse educators strongly agreed and 5 (n=18:27.8%) agreed, while 44 (n=118:37.3%) strongly agreed and 51 (n=118:43.2%) professional nurses agreed that they had planned learning activities that were in line with the educational requirements at different training levels. None of the nurse educators disagreed with the statement and only 18 (n=118:15.3%) of the professional nurses disagreed. A total of 3 (n=18:16.7%) of the nurse educators and 5 (n=118:4.2%) of the professional nurses strongly disagreed with the statement that they did not plan learning activities according to students' educational requirements.

Figure 4.34 indicates that 7 (n=18:38.9%) of the nurse educators strongly agreed and 4 (n=18:22.2%) agreed that they were given the responsibility to train professional nurses in the clinical supervision of nursing students and pupil enrolled nurses whereas only 2 (n=118:1.7%) of the professional nurses strongly agreed and 17 (n=118:14.4%) agreed to this statement. A total of 4 (n=18:22.2%) of the nurse educators and 51 (n=118:43.2%) of the professional nurses disagreed with this statement while 3

(n=18:16.7%) of the nurse educators and 48 (n=118:40.7%) of the professional nurses strongly disagreed that nurse educators had been given the responsibility to train them with regard to clinical supervision.

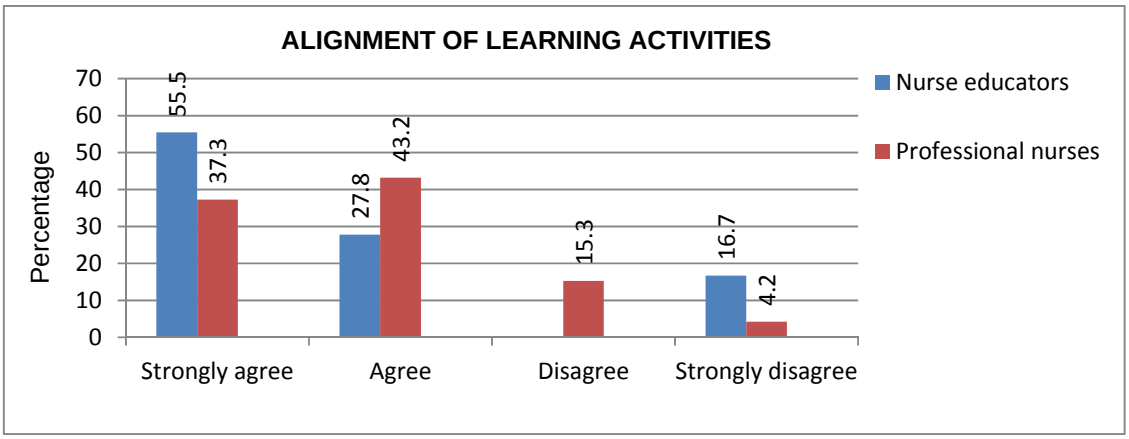

Figure 4.33: Alignment of learning activities with the educational requirements at different levels of training (Section D: Question 1.5: NE/PN)

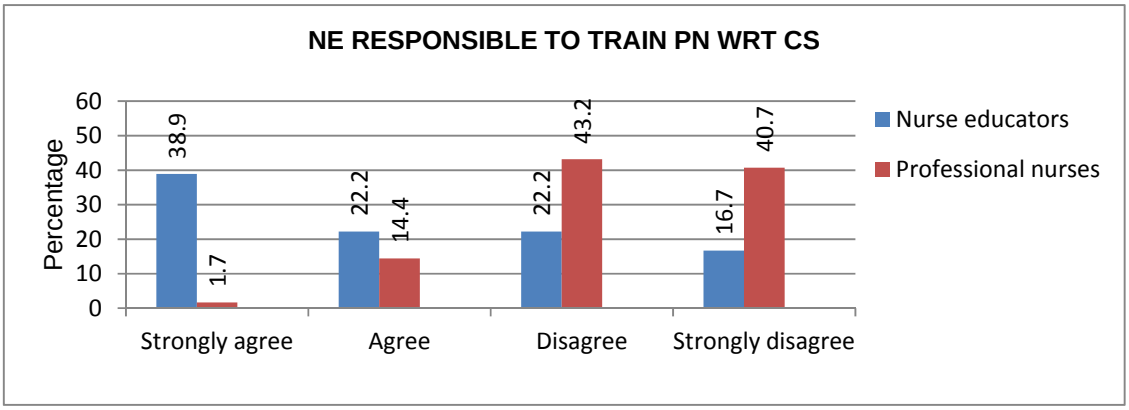

Figure 4.34: Response to statement that nurse educators (NE) are responsible for training professional nurses (PN) with regard to clinical supervision (CS) (Section D: Question 1.6: NE/PN)

Figure 4.35 shows that the majority of nurse educators (7;n=18:38.9%) either disagreed or strongly disagreed (5;n=18:27.8%) that they did not have effective communication with professional nurses regarding the learning outcomes for clinical placements to be achieved by nursing students and pupil enrolled nurses. A total of 54 (n=118:45.7%) of the professional nurses strongly disagreed and 52 (n=118:44%) disagreed that they had not been enlightened about the learning outcomes of students by nurse educators.

Only 2 (n=18:11.1%) of the nurse educators strongly agreed and 4 (n=18:22.2%) agreed whereas 4 (n=118:3.4%) of the professional nurses strongly agreed and 8 (n=118:6.9%) agreed with the statement.

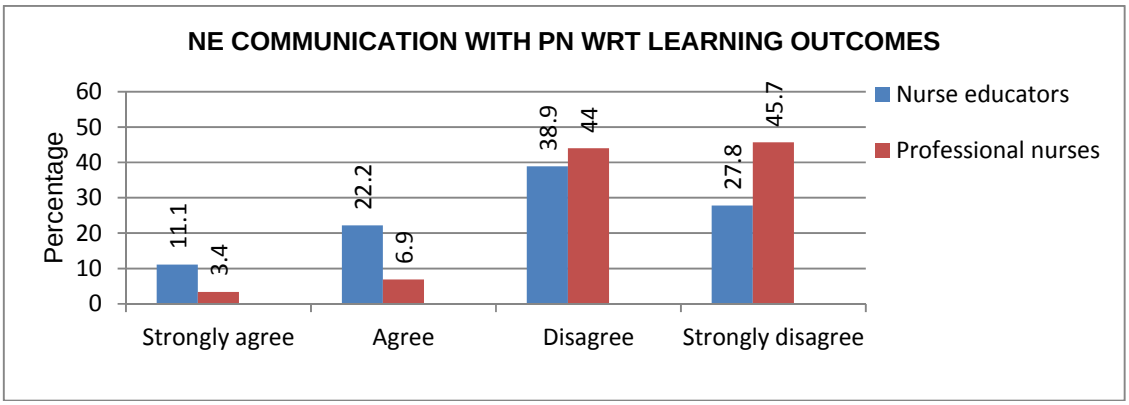

Figure 4.35: Response to statement concerning nurse educators' (NE) communication with professional nurses (PN) regarding to learning outcomes (Section D: Question 1.7: NE/PN)

Figure 4.36 shows that 6 (n=18:33.3%) of the nurse educators strongly agreed and 7 (n=18:38.9%) agreed that effective communication about learning outcomes took place with professional nurses in the clinical setting. A total of 3 (n=18:16.7%) of the nurse educators disagreed and 2 (n=18:11.1%) strongly disagreed with this statement.

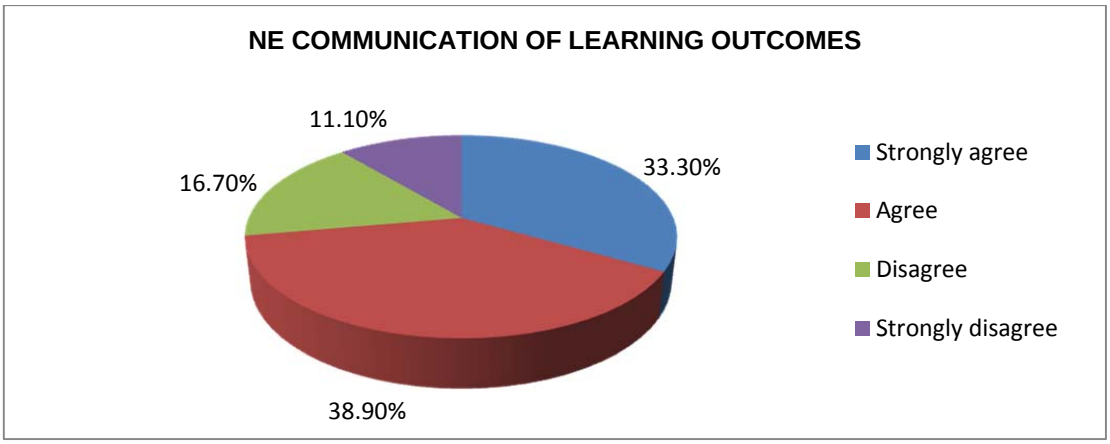

Figure 4.36: Response to statement concerning communication regarding to learning outcomes of nursing students (NS) and pupil enrolled nurses (PEN) (Section D: Question 1.8: NE/PN)

Figure 4.37 shows that 9 (n=18:50%) of the nurse educators strongly agreed while the majority of nursing students and pupil enrolled nurses (77;n=148:51.7%) agreed that they had received regular feedback immediately after completing a task. A total of 35 (n=148:23.7%) of the nursing students and pupil enrolled nurses strongly agreed where as 4 (n=18:22.2%) of the nurse educators agreed that regular feedback was provided. Only 2 (n=18:11.1%) of the nurse educators disagreed and 3 (n=18:16.7%) strongly disagreed, while 29 (n=148:19.5%) of the nursing students and pupil enrolled nurses disagreed and 8 (n=148:5.1%) strongly disagreed with the contents of this statement.

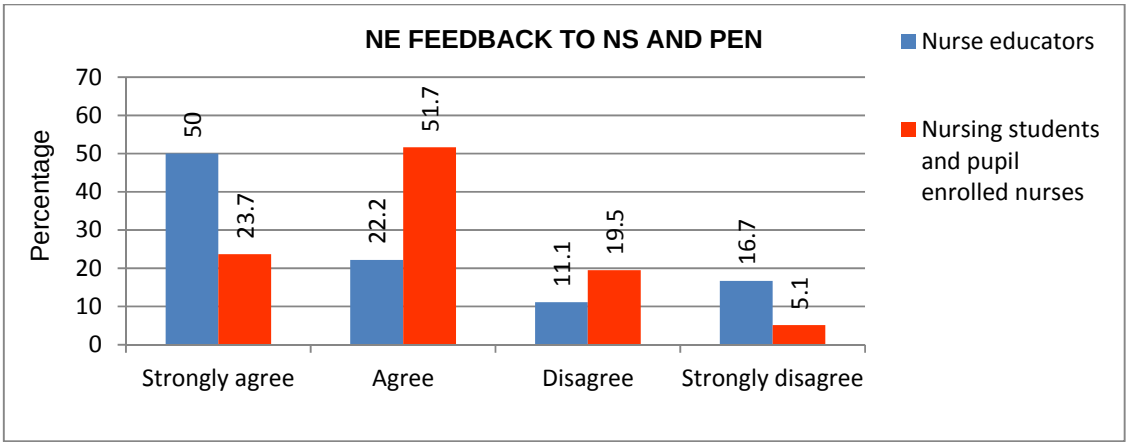

Figure 4.37: Response to statement concerning nurse educators' (NE) feedback to nursing students (NS) and pupil enrolled nurses (PEN) after completion of a task (Section D: Question 1.9: NE/PN and Section C: Question 1.9: NS/PEN)

Figure 4.38 illustrates the response of nurse educators to the pre-publication of clinical placement dates. Nurse educators (12;n=18:66.6%) strongly agreed that placement dates were published in advance, where as 5 (n=18:27.8%) agreed, nobody disagreed and only 1(n=18:5.6%) strongly disagreed that the placement dates for nursing students and pupil enrolled nurses had been planned before allocation to the clinical setting.

Figure 4.39 indicates that the majority of nurse educators (10;n=18:55.5%) strongly agreed that they had disclosed the clinical placement areas for nursing students and pupil enrolled nurses before they had been allocated to the clinical setting. A total of 5 (n=18:27.8%) of the nurse educators agreed, 2 (n=18:11.1%) disagreed and 1

(n=18:5.6%) strongly disagreed that these placement areas had been disclosed before allocation.

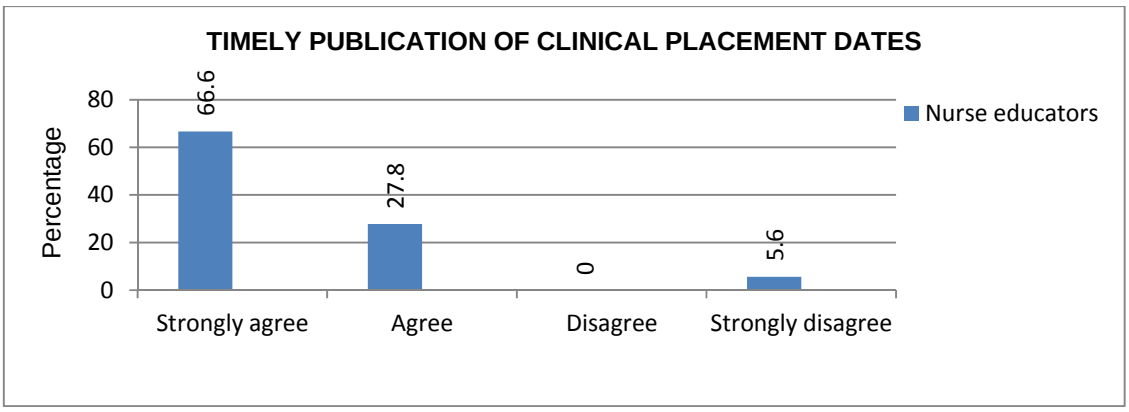

Figure 4.38: Response to statement concerning nurse educators' (NE) timely publication of clinical placement dates of nursing students (NS) and pupil enrolled nurses (PEN) (Section D: Question 1.10: NE/PN)

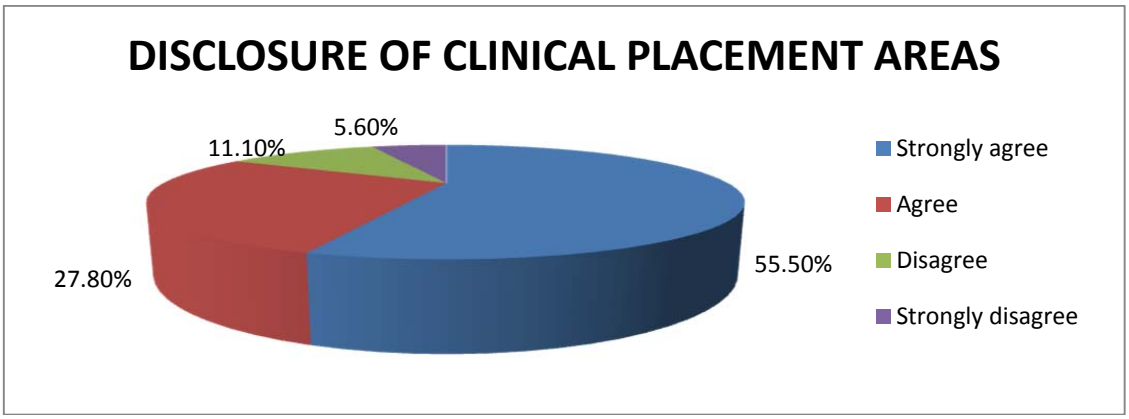

Figure 4.39: Response to statement concerning nurse educators' (NE) disclosure of clinical placement areas for nursing students (NS) and pupil enrolled nurses (PEN) (Section D: Question 1.11: NE/PN)

Figure 4.40 shows that 9 (n=18:50%) of the nurse educators in the SAMHS disagreed and 5 (n=18:27.7%) strongly disagreed with the statement that they had not provided professional nurses in the clinical learning environment with a structured clinical supervision programme for the guidance of nursing students and pupil enrolled nurses. Only 3 (n=18:16.7%) of the nurse educators strongly agreed and 1 (n=18:5.6%) agreed that no clinical supervision programme had been provided for professional nurses.

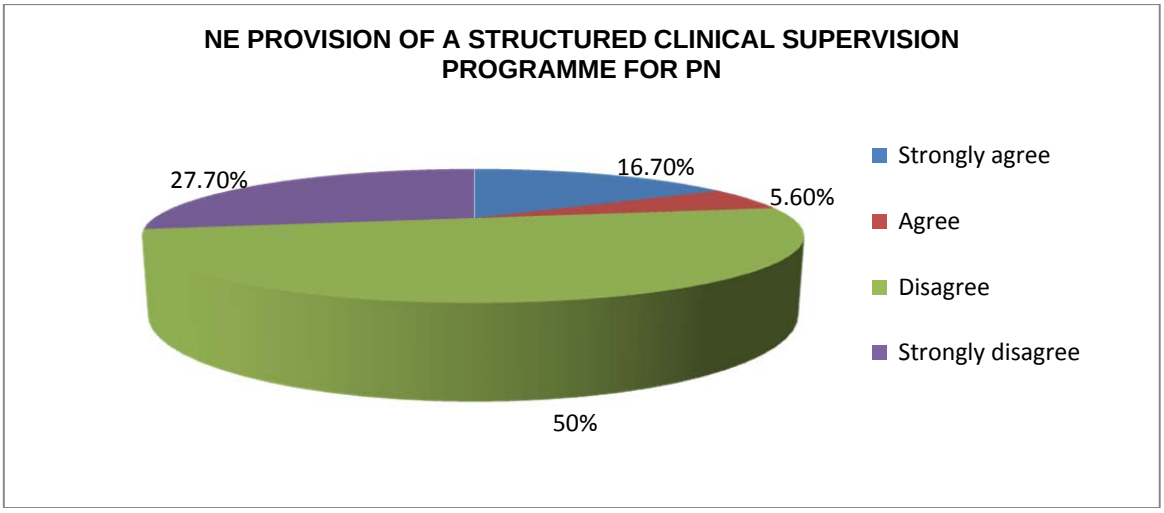

Figure 4.40: Response to statement concerning nurse educators' (NE) provision of a structured clinical supervision programme for professional nurses (PN) (Section D: Question 1.12: NE/PN)

Figure 4.41 shows that 14 (n=18:77.7%) of the nurse educators indicated that they had been involved with the assessment of the clinical competence of nursing students and pupil enrolled nurses. Only 3 (n=18:16.7%) of the nurse educators agreed, nobody disagreed and 1 (n=18:5.6%) strongly agreed with this statement.

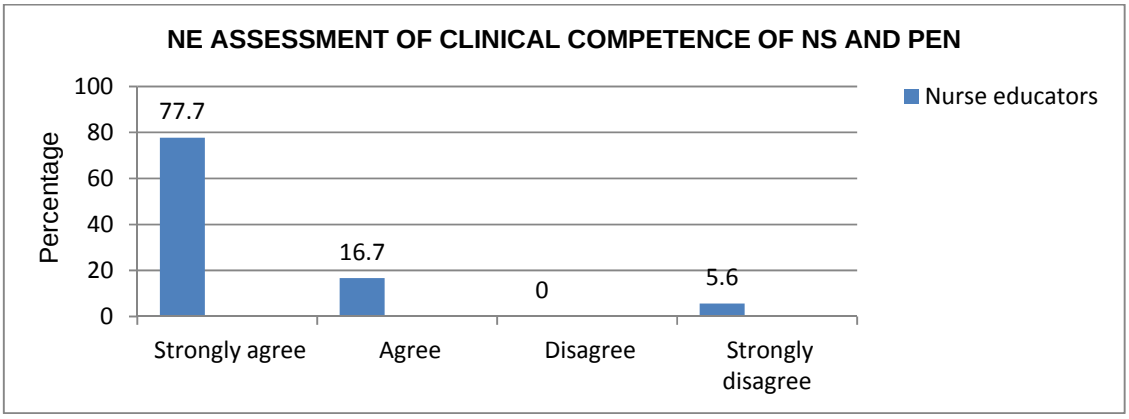

Figure 4.41: Nurse educators' (NE) assessment of clinical competence of nursing students (NS) and pupil enrolled nurses (PEN) (Section D: Question 1.13: NE/PN)

Figure 4.42 gives an indication that professional nurses were required to incorporate the responsibility of clinical supervision into their already busy workloads. A total of 44 (n=118:37.3%) of the professional nurses strongly agreed and 51 (n=118:43.2%)

agreed that the clinical supervision of nursing students and pupil enrolled nurses had become their responsibility. Only 18 (n=118:15.3%) of the professional nurses disagreed and 5 (n=118:4.2%) strongly disagreed that it was not expected of them to incorporate the responsibility of clinical supervision into their heavy workload.

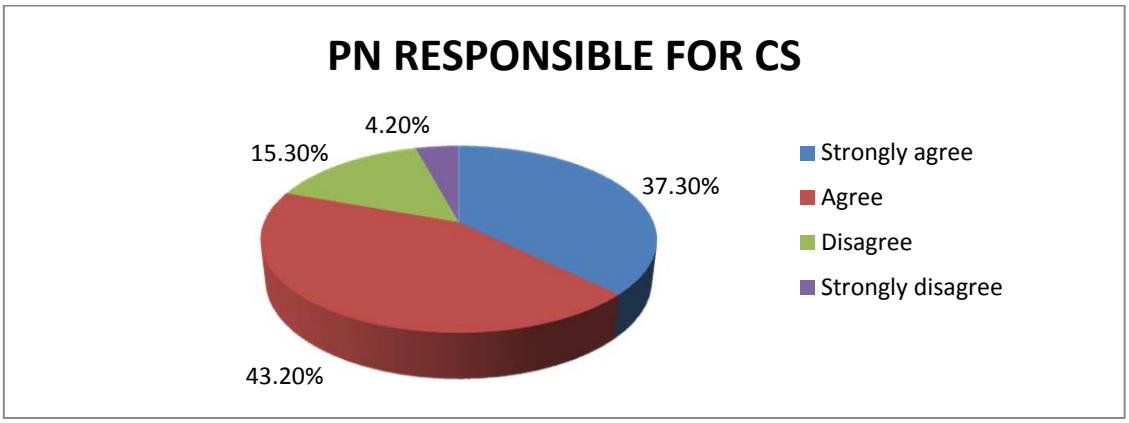

Figure 4.42: Professional nurses (PN) responsibility for clinical supervision (CS) (Section E: Question 1.5: NE/PN)

Figure 4.43 shows that 51 (n=118:43.2%) of the professional nurses disagreed and 48 (n=118:40.7%) strongly disagreed that they regarded the presence of nursing students and pupil enrolled nurses in the clinical setting as an extra burden. A total number of 17 (n=118:14.4%) agreed and only 2 (n=118:1.7%) strongly agreed with this statement.

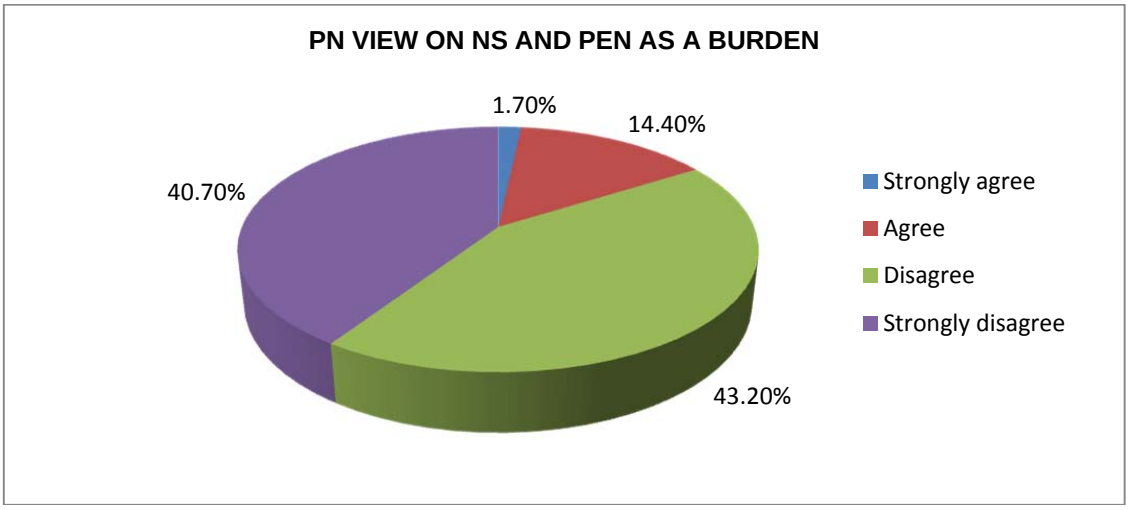

Figure 4.43: Professional nurses (PN) view of nursing students (NS) and pupil enrolled nurses (PEN) as an added burden (Section E: Question 1.6: NE/PN)

Figure 4.44 shows that 54 (n=118:45.7%) of the professional nurses strongly disagreed and 52 (n=118:44.1%) disagreed that they had not had no interest in the clinical supervision of nursing students and pupil enrolled nurses. A total of 4 (n=118:3.4%) of the professional nurses strongly agreed and 8 (n=118:6.8%) agreed with this statement.

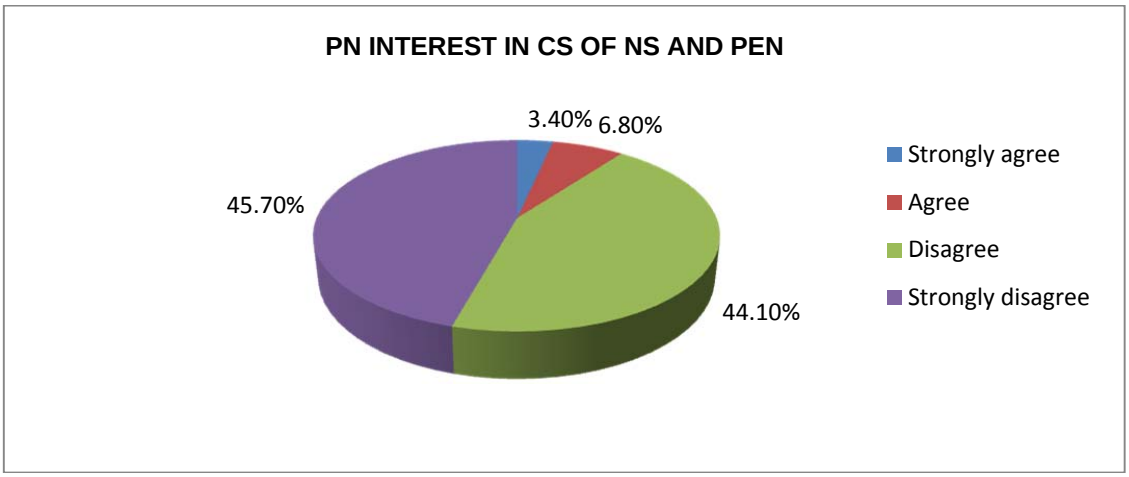

Figure 4.44: Professional nurses' (PN) interest in the clinical supervision (CS) of nursing students (NS) and pupil enrolled nurses (PEN) (Section E: Question 1.7: NE/PN)

Figure 4.45 shows that the majority of professional nurses (50;n=118:42.4%) agreed and 54 (n=118:45.8%) strongly agreed with the statement that they would like nurse educators to recognise and emphasise the value of their contribution to nursing students and pupil enrolled nurses' education. A few (9;n=118:7.6%) of the professional nurses disagreed and 5 (n=118:4.2%) strongly disagreed with this statement.

Figure 4.46 shows that 28 (n=118:23.7%) of the professional nurses strongly agreed and 61 (n=118:51.7%) agreed that they took responsibility for the clinical supervision of nursing students and pupil enrolled nurses supported by nurse educators located elsewhere. Only 23 (n=118:19.5%) of the professional nurses disagreed and 6 (n=118:5.1%) strongly disagreed with the statement that they took the responsibility for supervising students in the clinical learning environment.

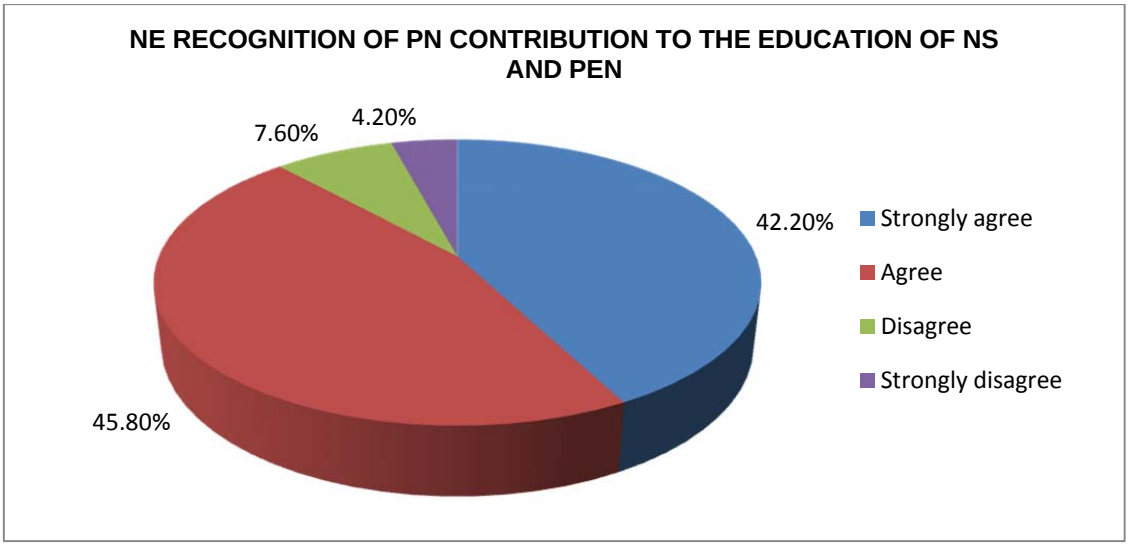

Figure 4.45: Nurse educators (NE) recognition of professional nurses (PN) contribution to the education of nursing students (NS) and pupil enrolled nurses' (PEN) (Section E: Question 1.8: NS/PN)

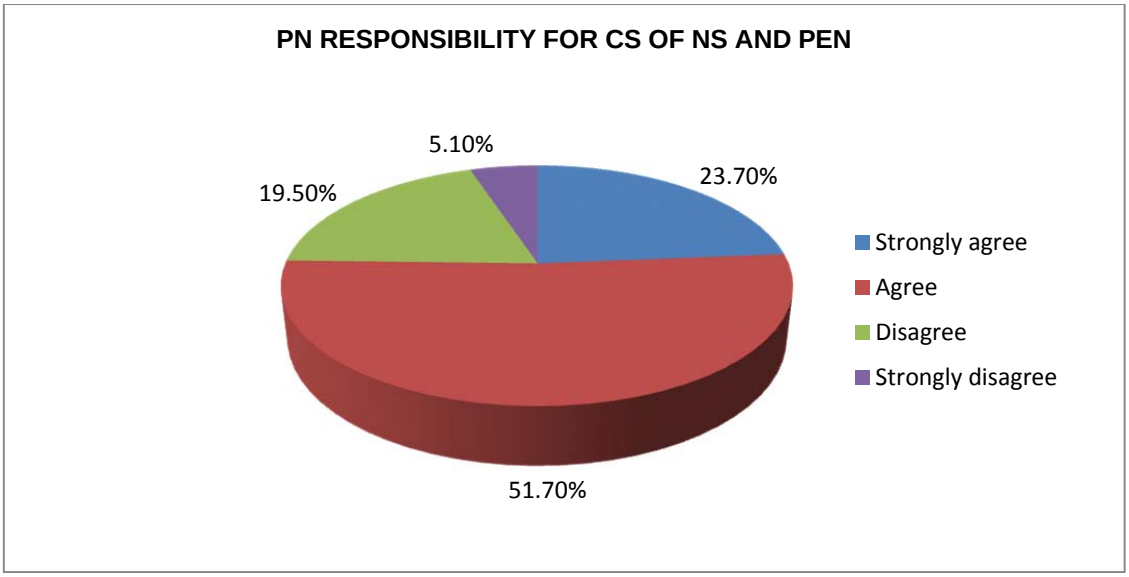

Figure 4.46: Professional nurses (PN) responsibility for the clinical supervision (CS) of nursing students (NS) and pupil enrolled nurses (PEN) (Section E: Question 1.9: NE/PN)

4.6 SECTION C: ROLES AND RESPONSIBILITIES OF NURSE EDUCATORS (NE) AND PROFESSIONAL NURSES (PN) IN THE CLINICAL SETTING

The following section gives an overview of the responses of nursing students and pupil enrolled nurses to specific statements regarding the roles and responsibilities of nurse educators and professional nurses in the clinical setting.

Figure 4.47 indicates that the majority of nursing students (38:n=104:36.5%) and pupil enrolled nurses (13;n=44:29.6%) disagreed with the statement that nurse educators and professional nurses experienced clinical supervision as an inconvenience.

Only 20 (n=104:19.6%) of the nursing students and 9 (n=44:20.3%) of the pupil enrolled nurses strongly disagreed with the statement. A total of 32 (n=104:31.1%) of the nursing students and 13 (n=44:29.1%) of the pupil enrolled nurses agreed that nurse educators and professional nurses experienced clinical supervision as an inconvenience, while 13 (n=104:12.8%) of the nursing students and 9 (n=44:21%) of the pupil enrolled nurses strongly disagreed.

Figure 4.48 shows that the majority of nursing students and pupil enrolled nurses (53;n=148:35.8%) disagreed and 30 (n=148:20.3%) strongly disagreed that nurse educators experienced clinical supervision as time consuming. Only 16 (n=148:10.8%) of the nursing students and pupil enrolled nurses strongly agreed and 49 (n=148:33.1%) agreed with this statement.

Figure 4.49 shows that the majority of nursing students and pupil enrolled nurses (59:n=148:39.9%) strongly agreed and 50 (n=148:33.8%) agreed that nurse educators, employed by the SAMHS, were only seen in the clinical setting when they had to assess students. A few (27;n=148:18.2%) of the nursing students and pupil enrolled nurses disagreed and 12 (n=148:8.1%) strongly disagreed with this statement.

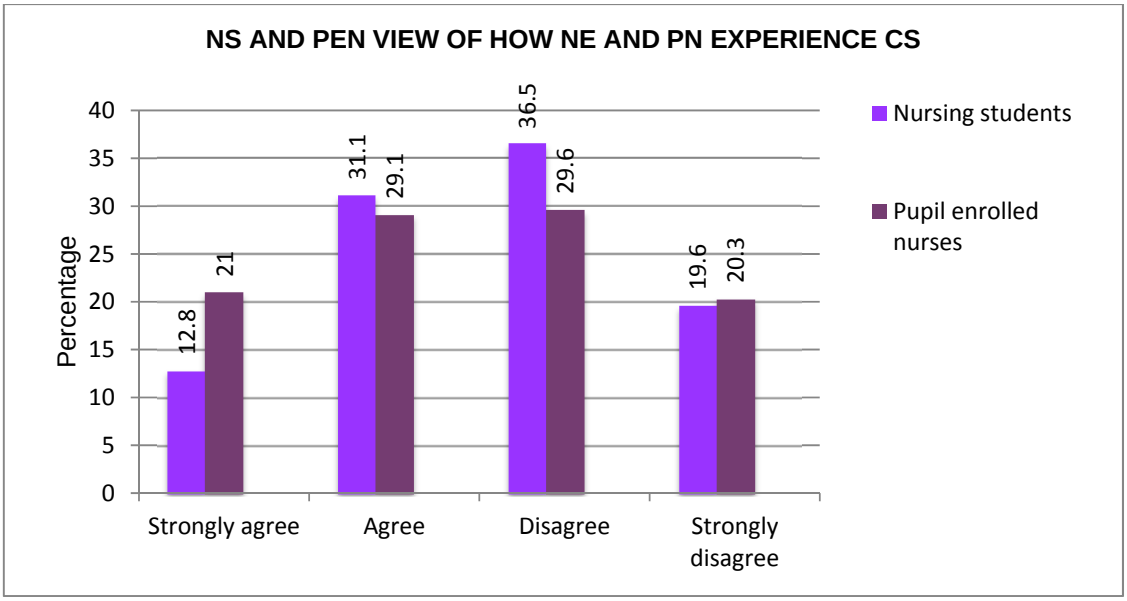

Figure 4.47: Nursing students' (NS) and pupil enrolled nurses' (PEN) view of how nurse educators (NE) and professional nurses (PN) experience clinical supervision (CS) (Section C: Question 1.1: NS/PEN)

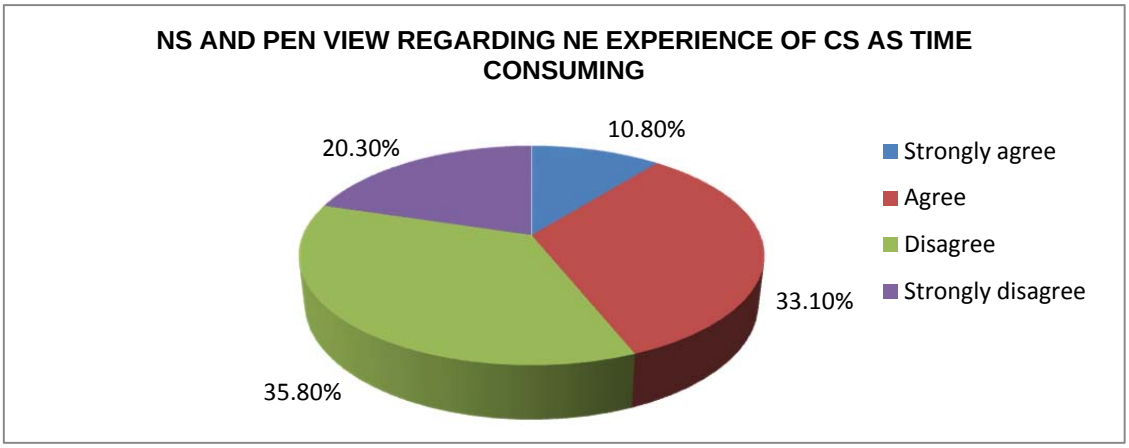

Figure 4.48: Nursing students' (NS) and pupil enrolled nurses' (PEN) view of nurse educators' (NE) experience of clinical supervision (CS) as time consuming (Section C: Question 1.2: NS/PEN)

Figure 4.50 shows that 47 (n=148:31.7%) of the nursing students and pupil enrolled nurses disagreed that nurse educators had a formal agreement or contract with them, while 45 (n=148:30.4%) agreed with the statement. A total of 22 (n=148:14.9%) of the nursing students and pupil enrolled nurses strongly agreed, and 34 (n=148:23%) strongly disagreed that a formal contract existed between the latter category and nurse educators.

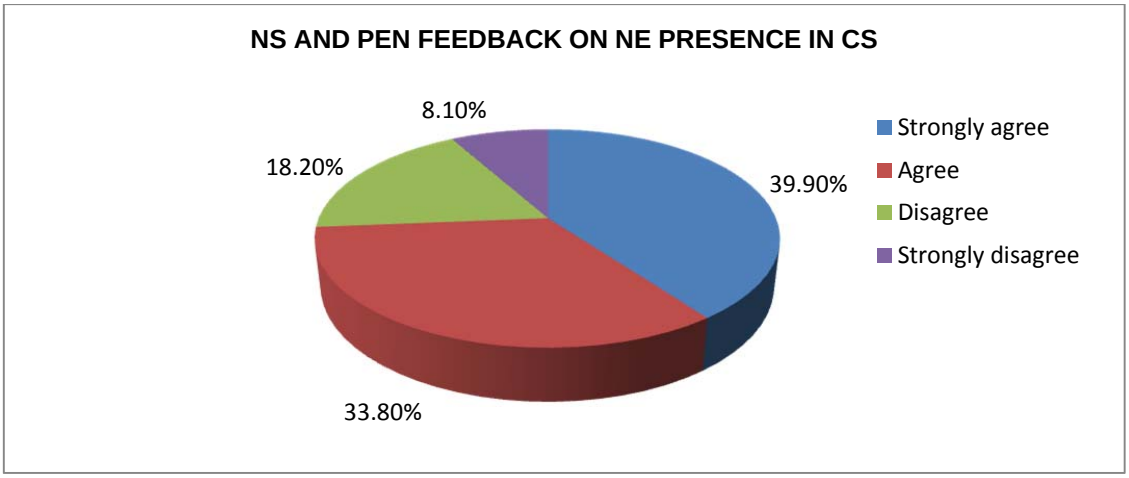

Figure 4.49: Nursing students' (NS) and pupil enrolled nurses' (PEN) feedback on nurse educators' (NE) presence in the clinical setting (Section C: Question 1.3: NS/PEN)

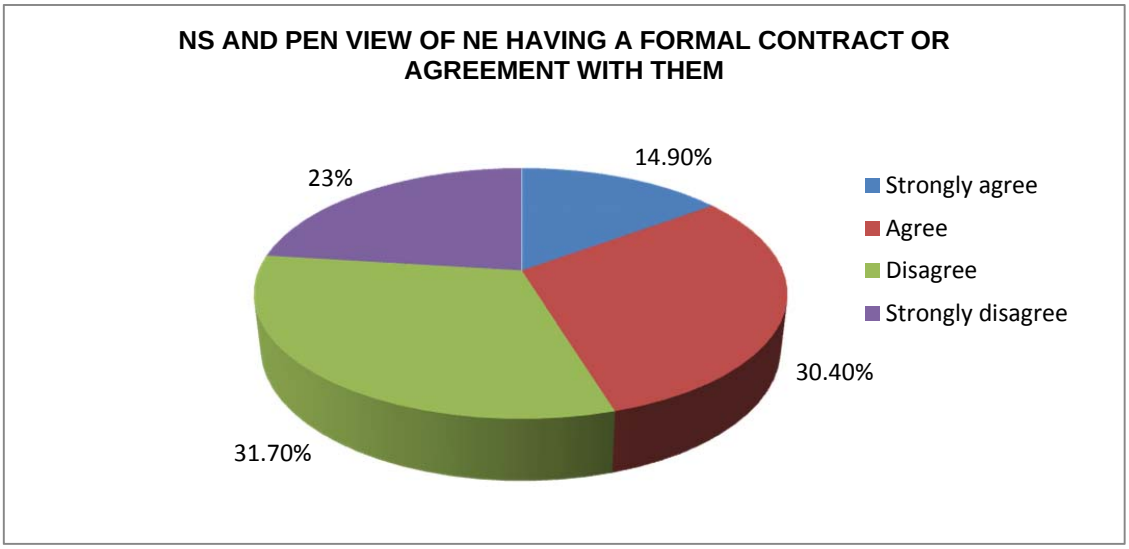

Figure 4.50: Nursing students' (NS) and pupil enrolled nurses' (PEN) view of nurse educators (NE) having a formal contract or agreement with them (Section C: Question 1.6: NS/PEN)

Figure 4.51 shows that 85 (n=148:57.4%) of the nursing students and pupil enrolled nurses agreed that nurse educators had a verbal agreement with them. Only 29 (n=148:19.6%) of the nursing students and pupil enrolled nurses strongly agreed while 23 (n=148:15.5%) disagreed and 11 (n=148:7.5%) strongly disagreed with the statement.

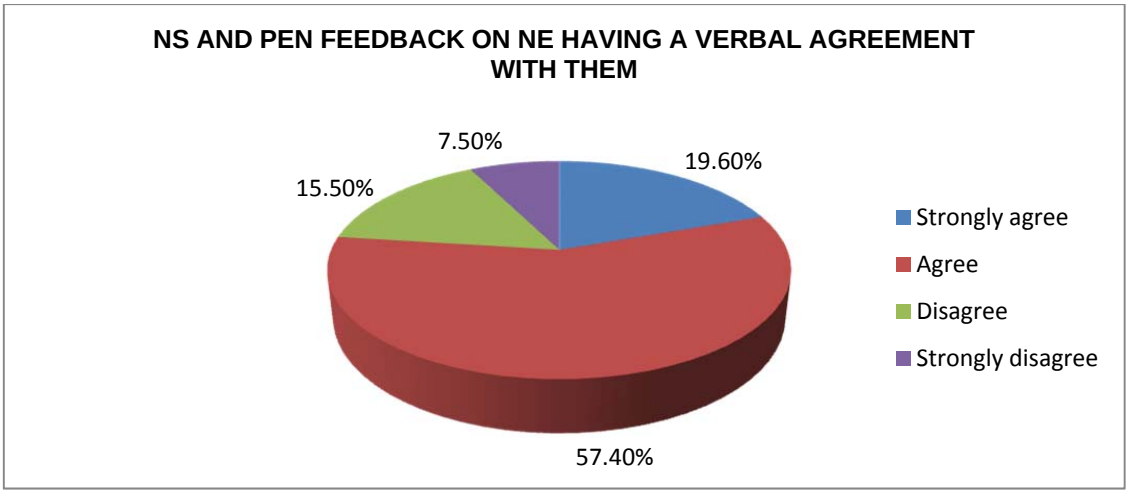

Figure 4.51: Nursing students' (NS) and pupil enrolled nurses' (PEN) feedback on nurse educators (NE) having a verbal agreement with them (Section C: Question 1.7: NS/PEN)

Figure 4.52 reveals that 70 (n=148:47.3%) nursing students and pupil enrolled nurses strongly agreed that nurse educators needed to work alongside students to demonstrate how to integrate theory into practice. A total of 44 (n=148:29.7%) of the nursing students and pupil enrolled nurses agreed and 20 (n=148:13.5%) disagreed with 14 (n=148:9.5%) strongly disagreeing with the statement.

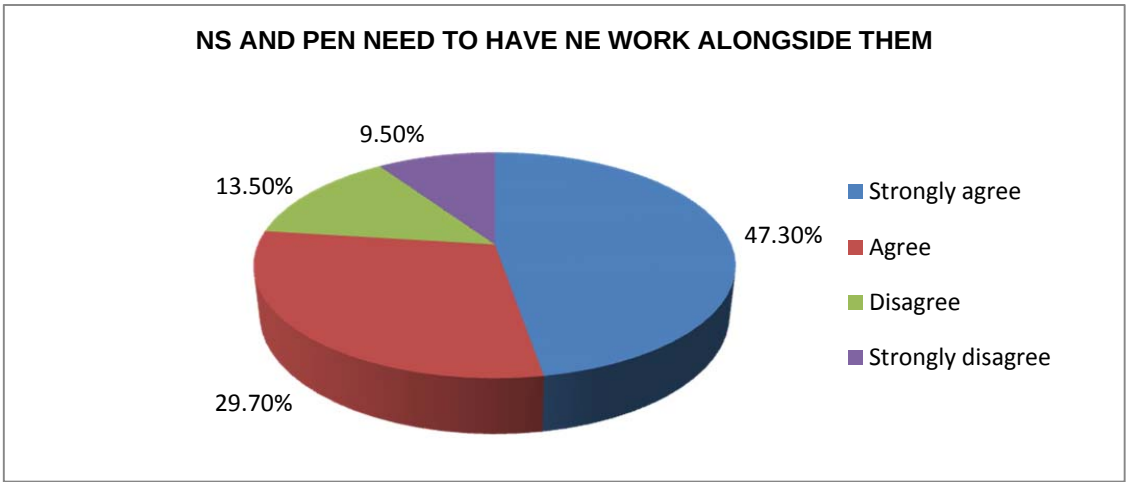

Figure 4.52: Response to statement that nursing students (NS) and pupil enrolled nurses (PEN) need to have nurse educators (NE) work alongside them (Section C: Question 1.10: NS/PEN)

Figure 4.53 shows that 56 (n=148:37.8%) of the nursing students and pupil enrolled nurses strongly agreed that professional nurses had not allocated students to the clinical setting according to their level of training. Only 45 (n=148:30.4%) of the nursing students and pupil enrolled nurses agreed where as 32 (n=148:21%) disagreed and 16 (n=148:10.8%) strongly disagreed with this statement.

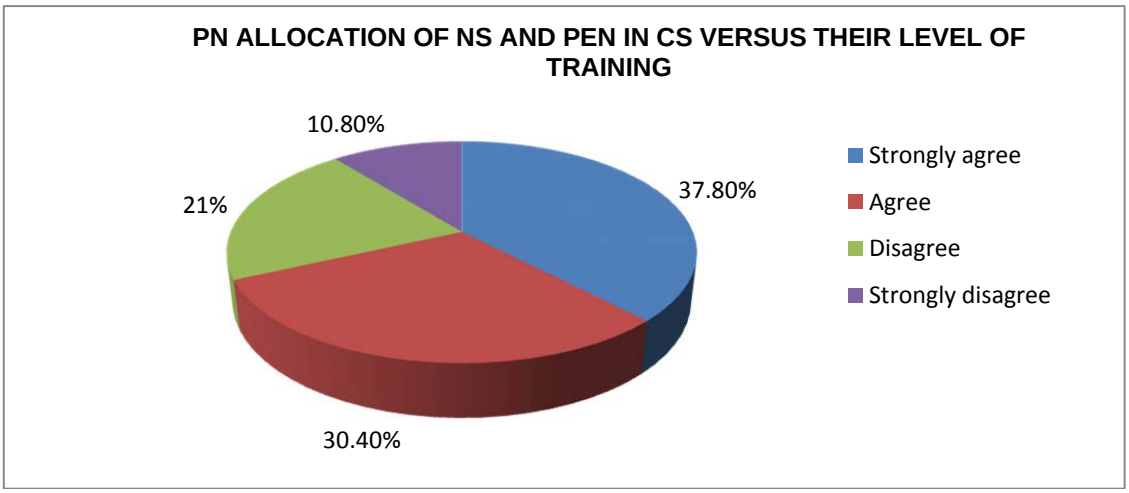

Figure 4.53: Response to statement concerning professional nurses' (PN) allocation of nursing students (NS) and pupil enrolled nurses (PEN) to the clinical setting versus their level of training (Section C: Question 2.2 : NS/PEN)

Figure 4.54 indicates that 65 (n=148:43.9%) of the nursing students and pupil enrolled nurses strongly agreed that professional nurses were not in favour of releasing students to attend clinical supervision sessions at the training institution because the students served as part of the working force in the clinical setting. A total of 48 (n=148:32.4%) of the nursing students and pupil enrolled nurses agreed, while only a few (22;n=148:14.9%) disagreed and 13 (n=148:8.8%) strongly disagreed with this statement.

Figure 4.55 reveals that 67 (n=148:45.2%) of the nursing student and pupil enrolled nurse group disagreed and 26 (n=148:17.6%) strongly disagreed with the statement that professional nurses gave them appropriate guidance; which meant that they did not need to consult their peers in the clinical setting. The nursing students and pupil

enrolled nurses that agreed came to total of 37 (n=148:25%) and only 18 (n=148:12.2%) strongly agreed with the statement.

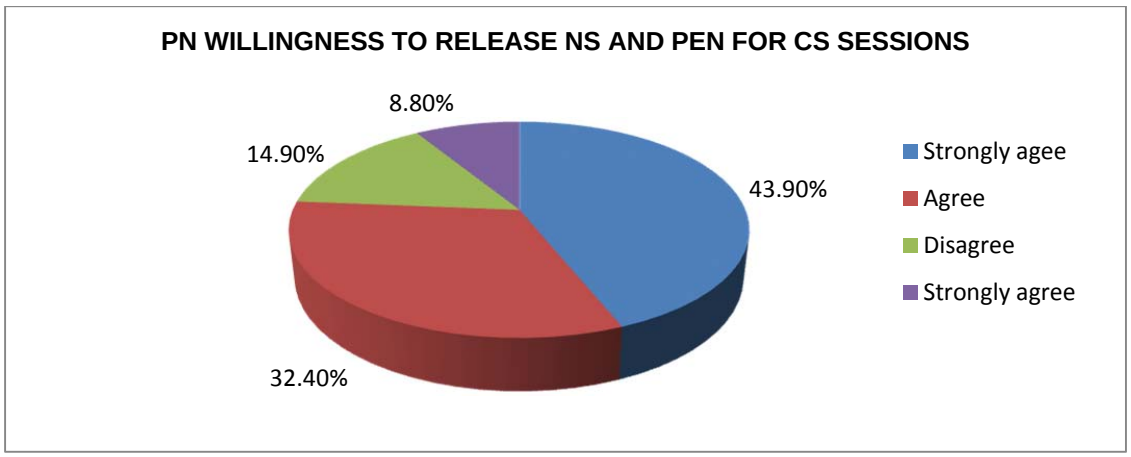

Figure 4.54: Professional nurses (PN) willingness to release nursing students (NS) and pupil enrolled nurses (PEN) for clinical supervision (CS) sessions (Section C: Question 2.3: NS/PEN)

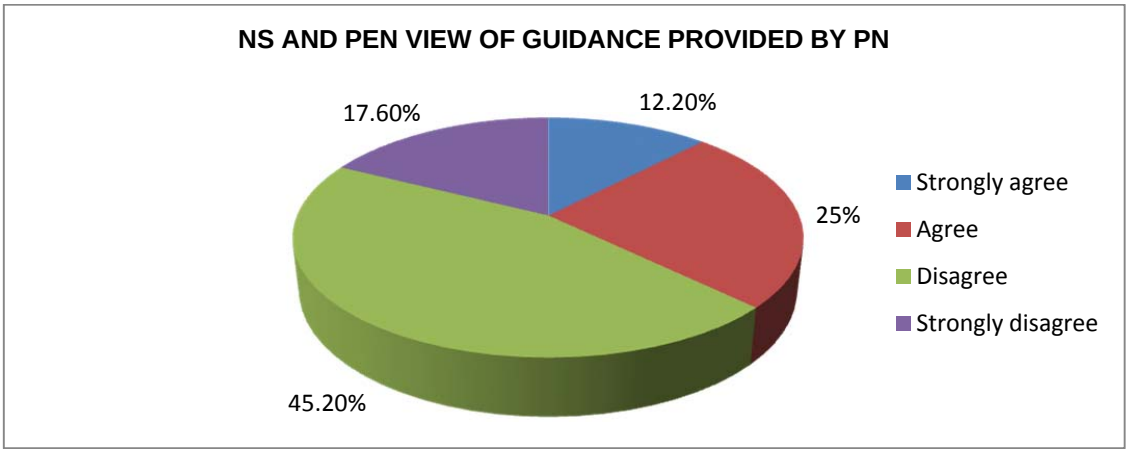

Figure 4.55: Nursing students (NS) and pupil enrolled nurses (PEN) view of guidance provided by professional nurses (PN) (Section C: Question 2.4: NS/PEN)

Figure 4.56 shows that 56 (n=148:37.7%) of the nursing students and pupil enrolled nurses disagreed and 43 (n=148:29.1%) strongly disagreed with the statement that professional nurses did not have a teaching function. A total of 18 (n=148:12.2%) strongly agreed and 31 (n=148:21%) agreed with this statement.

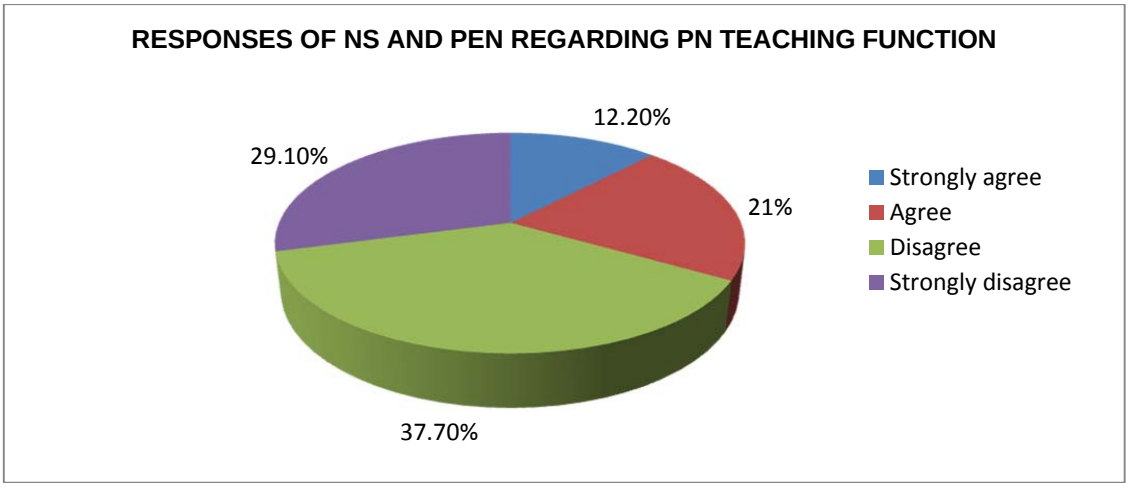

Figure 4.56: Responses of nursing students (NS) and pupil enrolled nurses (PEN) regarding professional nurses' (PN) teaching function (Section C: Question 2.5: NS/PEN)

Figure 4.57 shows that 71 (n=148:48%) of the nursing students and pupil enrolled nurses strongly agreed and 47 (n=148:31.7%) agreed that a heavy workload in the clinical setting limited the opportunities for proper teaching and guidance by nurse educators and professional nurses. Only 21 (n=148:14.2%) of the nursing students and pupil enrolled nurses disagreed and 9 (n=148:6.1%) agreed with this statement.

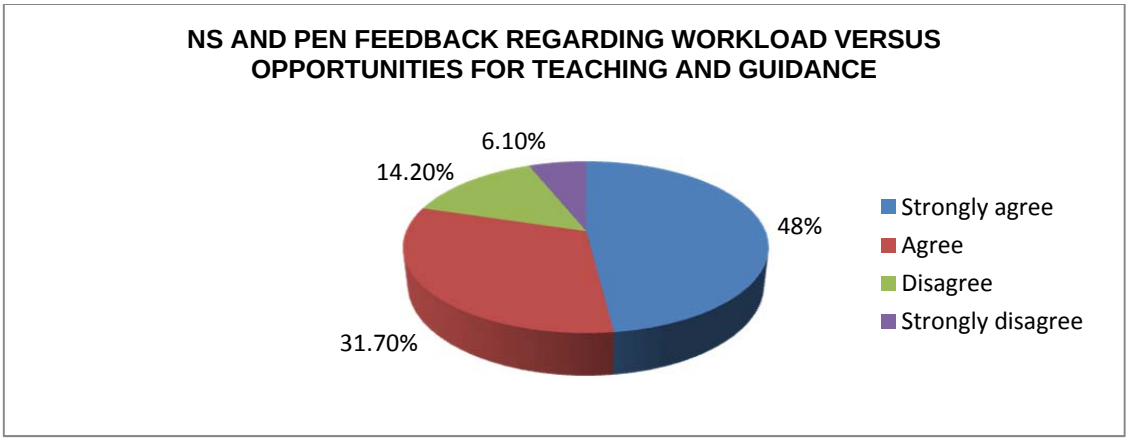

Figure 4.57: Nursing students' (NS) and pupil enrolled nurses' (PEN) feedback regarding workload versus opportunities for proper teaching and guidance (Section C: Question 3.1 NS/PEN)

Figure 4.58 shows that 84 (n=148:56.8%) of the nursing students and pupil enrolled nurses strongly agreed and 50 (n=148:33.7%) agreed that a staff shortage in the clinical learning environment limited the opportunities for proper teaching and guidance during supervision. A total of 8 (n=148:5.4%) disagreed and 6 (n=148:4.1%) strongly disagreed with this statement.

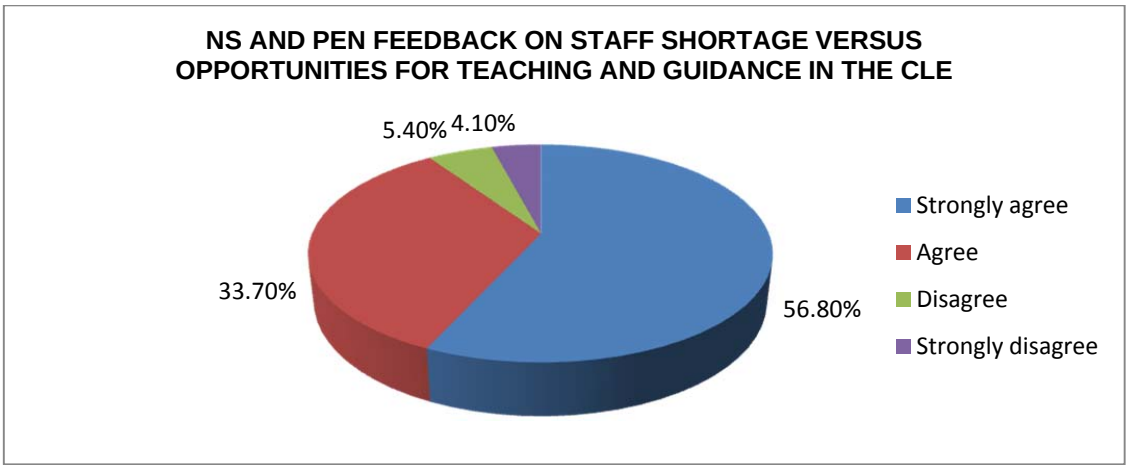

Figure 4.58: Nursing students (NS) and pupil enrolled nurses (PEN) feedback on staff shortage versus opportunities for teaching and guidance in the clinical learning environment (CLE) (Section C: Question 3.2: NS/PEN)

Figure 4.59 indicates that a total number of 50 (n=148:33.8%) of the nursing students and pupil enrolled nurses strongly agreed and 57 (n=148:38.5%) agreed that they would have adequate clinical skills upon completion of their education and training. A few members of the latter category (29;n=148:19.6%) disagreed and 12 (n=148:8.1%) strongly disagreed with this statement.

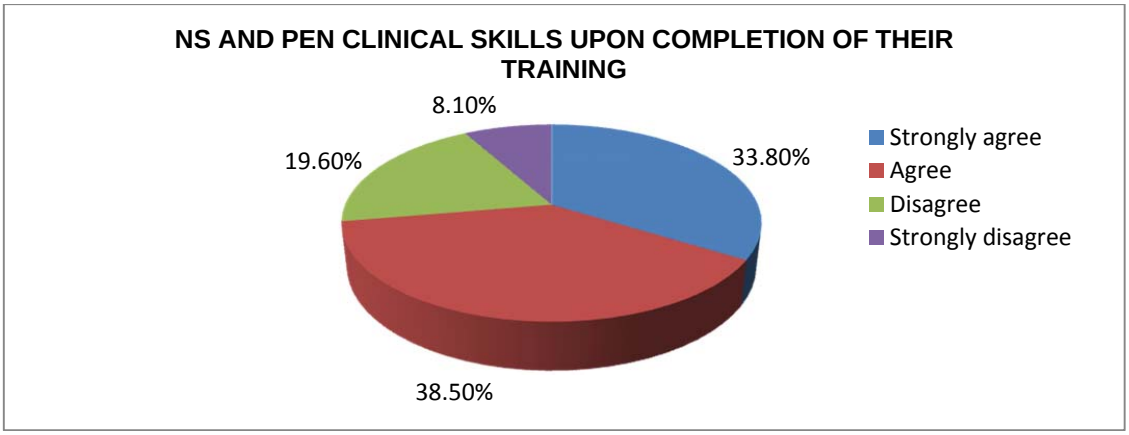

Figure 4.59: Nursing students' (NS) and pupil enrolled nurses' (PEN) clinical skills upon completion of their training (Section C: Question 3.3: NS/PEN)

Figure 4.60 shows that 58(n=148:39.2%) nursing students and pupil enrolled nurses agreed, while 33 (n=148:22.3%) of the latter category strongly agreed that they did not get adequate supervision in the clinical setting because it was assumed that they knew most of the work. Only 44 (n=148:29.7%) were of the opinion that the clinical supervision had been adequate and 13 (n=148:8.8%) strongly agreed with this statement.

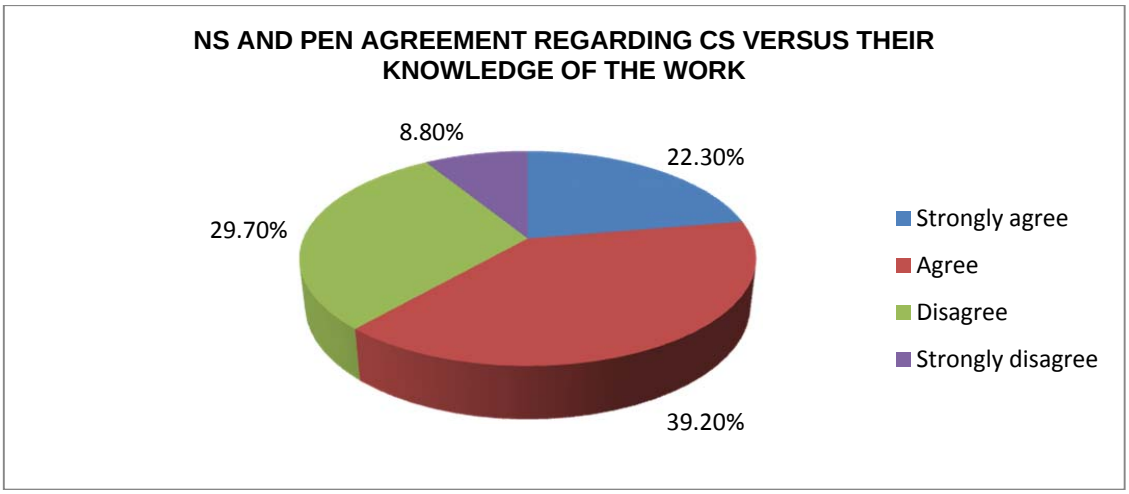

Figure 4.60: Nursing students' (NS) and pupil enrolled nurses' (PEN) agreement regarding the amount of clinical supervision (CS) versus their knowledge of the work (Section C: Question 3.4: NS/PEN)

Figure 4.61 indicates that 52 (n=148:35.2%) of the nursing students and pupil enrolled nurses were of the opinion that communication between the training institution and professional nurses in the clinical setting was adequate, whereas 54 (n=148:36.5%) reported it being inadequate. A total of 19 (n=148:12.8%) of the nursing students and pupil enrolled nurses strongly agreed with the statement that communication between the academic institution and the clinical setting was adequate while 23 (n=148:15.5%) disagreed strongly.

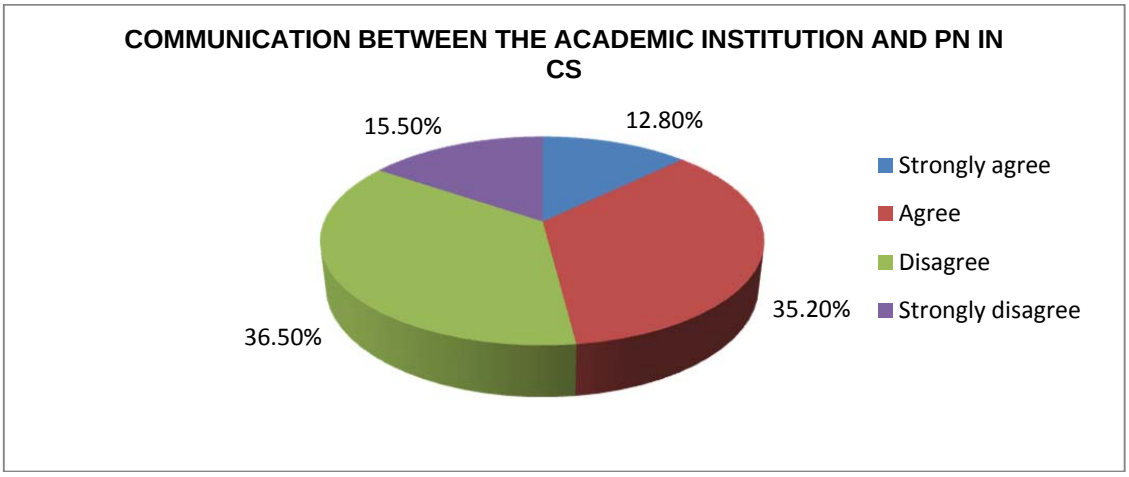

Figure 4.61: Communication between the academic institution and professional nurses (PN) in the clinical learning environment (CLE) (Section C: Question 3.5: NS/PEN)

Figure 4.62 indicates that 57 (n=148:38.5%) of the nursing students and pupil enrolled nurses agreed and 33 (n=148:22.3%) strongly agreed that the learning environment in the SAMHS provided adequate learning experiences. A total of 44 (n=148:29.7) of the nursing students and pupil enrolled nurses disagreed, and 14 (n=148:9.5%) strongly disagreed with this the statement.

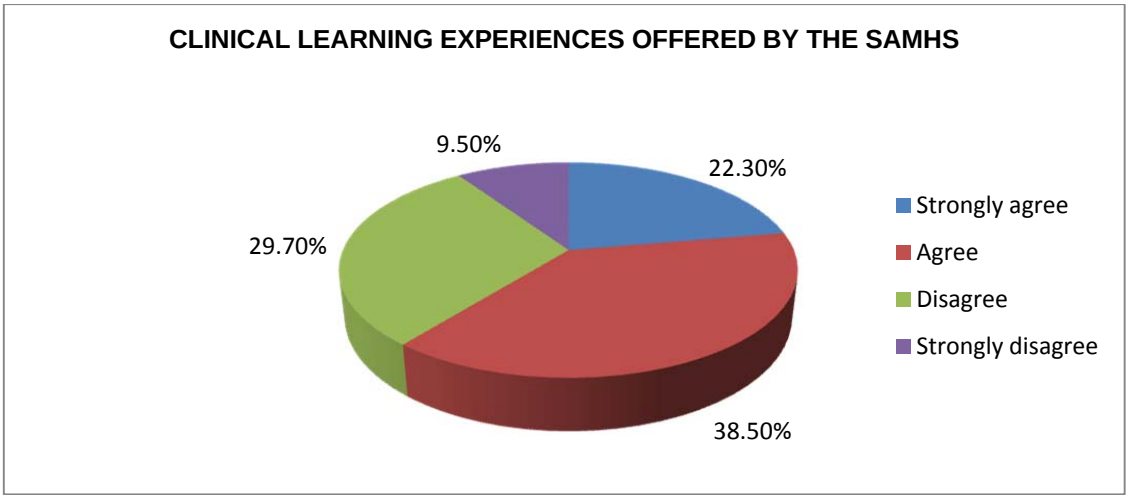

Figure 4.62: Clinical learning experiences offered by the SAMHS (Section C: Question 36: NS/PEN)

Figure 4.63 reveals that the majority (73;n=148:49.3%) of nursing students and pupil enrolled nurses disagreed and 16 (n=148:10.8%) strongly disagreed that clinical supervision sessions were conducted in isolation and that the previous sessions had not been considered. Only 17 (n=148:11.5%) strongly agreed and 42 (n=148:28.4%) agreed with this statement.

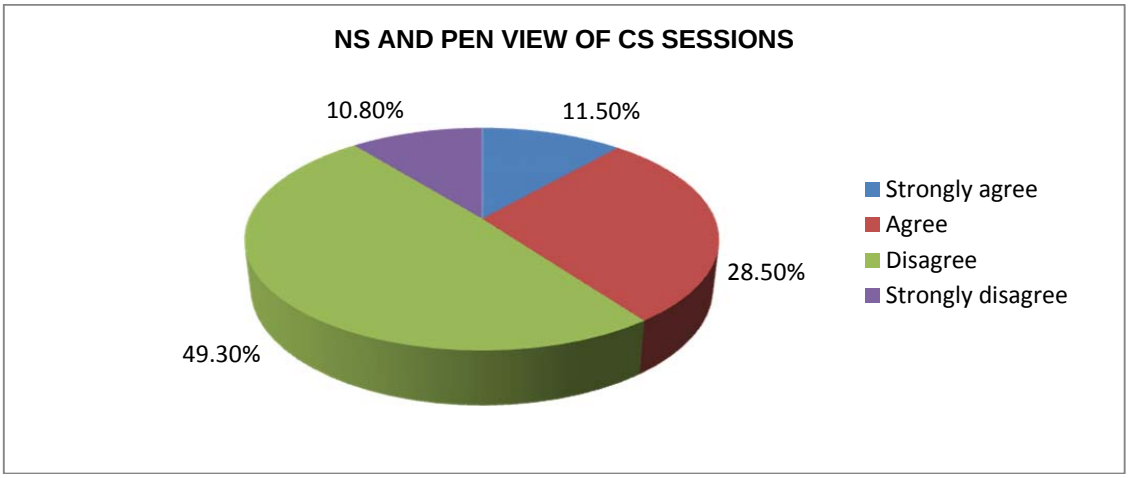

Figure 4.63: Nursing students (NS) and pupil enrolled nurses (PEN) view of clinical supervision sessions (Section C: Question 3.7: NS/PEN)

Figure 4.64 depicts that 48 (n=148:32.4%) of the nursing students and pupil enrolled nurses strongly agreed and 62 (n=148:41.9%) agreed that strong evidence existed for the discrepancy between classroom theory and the learning that took place in the clinical setting. A total of 27 (n=148:18.2%) of the latter category disagreed and 11 (n=148:7.5%) strongly disagreed with this statement.

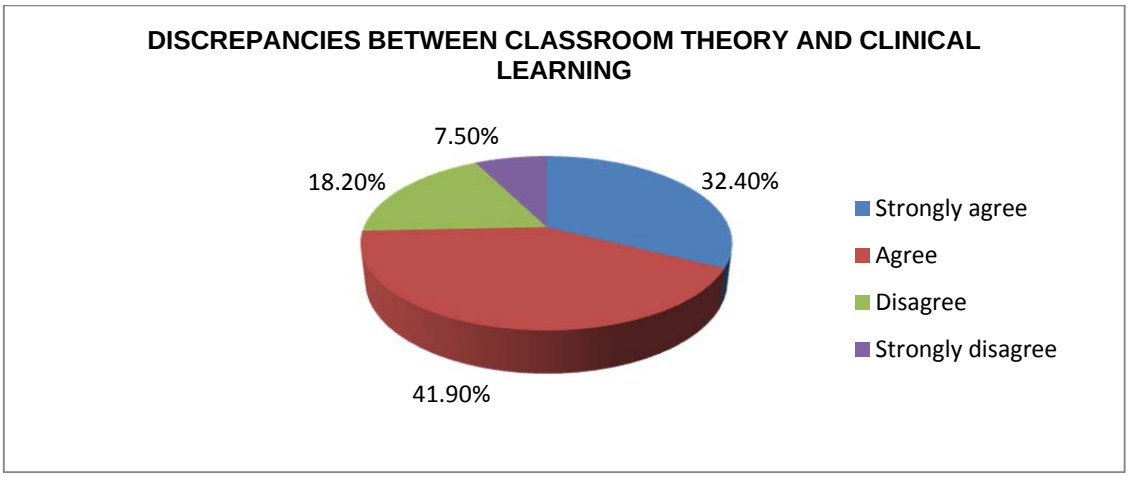

Figure 4.64: Discrepancies between classroom theory and clinical learning (Section C: Question 3.8: NS/PEN)

Figure 4.65 shows that 66 (n=148:44.6%) of the nursing students and pupil enrolled nurses strongly agreed and 67 (n=148:45.3%) agreed that clinical supervision offered them the opportunity to learn from mistakes without fear of embarrassment. Only a few (11;n=148:7.4%) of the students disagreed and 4 (n=148:2.7%) strongly agreed with this statement.

Figure 4.66 indicates that 38 (n=148:26.4%) of the nursing students and pupil enrolled nurses strongly agreed and 50 (n=148:33.7%) agreed that clinical supervision in the SAMHS was inadequate. Only 30 (n=148:20.3%) of the nursing students and pupil enrolled nurses disagreed and 29 (n=148:19.6%) agreed on with this statement.

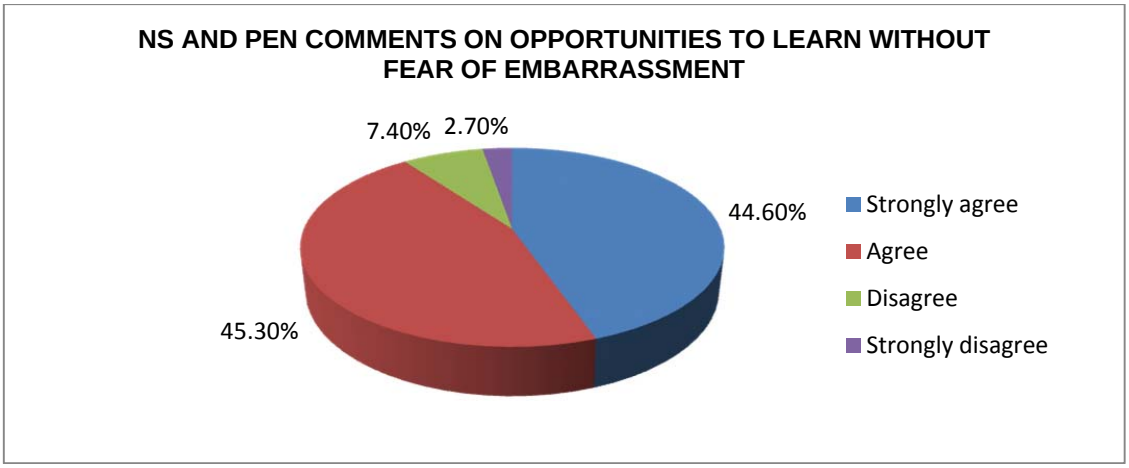

Figure 4.65: Nursing students' (NS) and pupil enrolled nurses' (PEN) comments on opportunities to learn without fear of embarrassment (Section C: Question 3.9: NS/PEN)

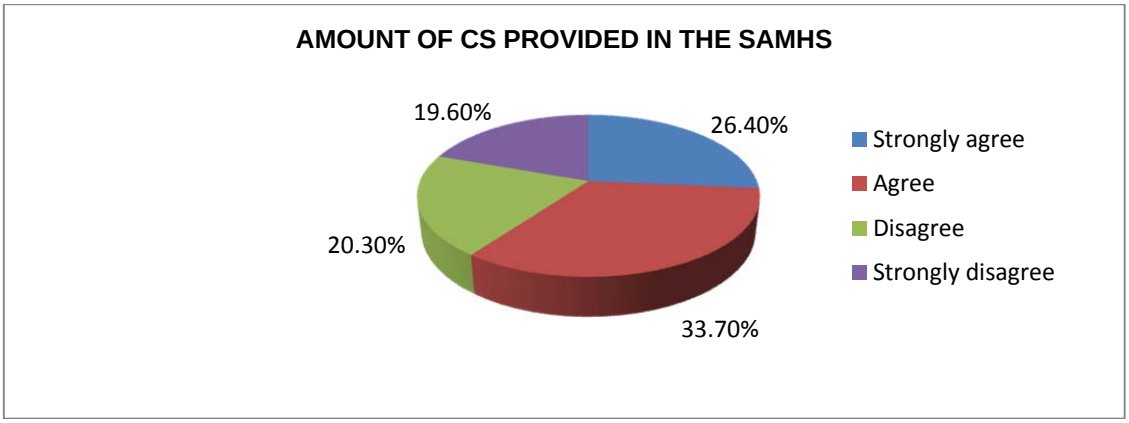

Figure 4.66: Amount of clinical supervision (CS) provided in the SAMHS (Section C: Question 3.10: NS/PEN)

Figure 4.67 shows the recommendations that nurse educators in the SAMHS made with regard to the improvement of clinical supervision for nursing students and pupil enrolled nurses.

Only 2 (n=18:11.1%) of the nurse educators were of opinion that nursing students and pupil enrolled nurses did not need to be utilised as part of the workforce in the clinical setting. It was felt that when they did form part of the workforce, time that could be spent on clinical supervision was limited.

One nurse educator (1:n=18:5.6%) was of the opinion that other health care departments such as medical practitioners and social workers needed to be involved in nursing students' and pupil enrolled nurses' clinical supervision in order to broaden their health service knowledge. It was furthermore revealed that nurse educators and professional nurses (15;n=136:11.1%) needed to be knowledgeable of the theoretical and clinical components of nursing. The rationale for this was that it would allow them to teach nursing students and pupil enrolled nurses and to produce competent future professional- and enrolled nurses.

One nurse educators (1:n=18:5.6%) said that nursing students and pupil enrolled nurses should not be utilised to accompany patients to neighbouring hospitals, seeing that this interfered with the time that nurse educators could have spent with students in the clinical setting. A total of 2 (n=18:11.1%) of the nurse educators felt that more time should be spent supervising with nursing students and pupil enrolled nurses.

The appointment of mentors and preceptors in the SAMHS was suggested by 4 (n=18:22.2%) of the nurse educators seeing that it would enhance clinical supervision. In the absence of this possibility (appointing mentors and preceptors), it was reported that nurse educators (2;n=18:11.1%) have the responsibility to enhance the clinical supervision of nursing students and pupil enrolled nurses and that they have to be involved with formative and summative clinical assessments. A total of 9 (n=18:50%) of the nurse educators said that the establishment of clinical departments in all the military hospitals were of the utmost importance for the enhancement of clinical supervision.
Weekly contact sessions of 45 minutes per session with nursing students and pupil enrolled nurses in the clinical setting were suggested by 1 (n=18:5.6%) of the nurse educators. Feedback on the competency of the clinical skills exercised needed to be given to students after assessment by nurse educators (1;n=18:5.6%). One newly appointed nurse educator (1;n=18:5.6%) in the SAMHS did not have any recommendations with regard to the improvement of clinical supervision of nursing students and pupil enrolled nurses.

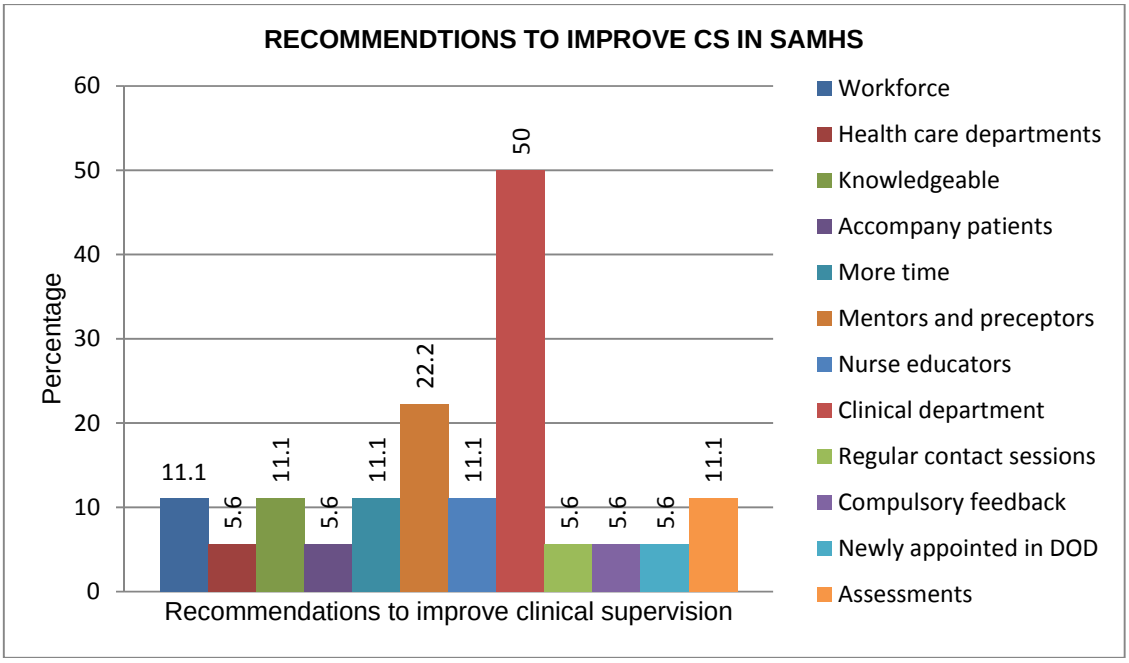

Figure 4.67: Recommendations by nurse educators (NE) improving clinical supervision (CS) in the SAMHS (Section D: Question 2: NE/PN)

Figure 4.68 gives an indication of the recommendations that professional nurses made regarding the improvement of clinical supervision in the SAMHS.

A total of 40 (n=118:34%) of the professional nurses suggested that nurse educators needed to be actively involved in the clinical supervision of nursing students and pupil enrolled nurses. Professional nurses (6;n=118:5.1%) stated that nursing students and pupil enrolled nurses had to be orientated with regard to basic clinical skills before they were sent to practice in the clinical setting. Proper guidelines from the training institution with regard to the amount of hours that should be set aside for nursing students and pupil enrolled nurses would be appreciated by professional nurses (7;n=118:5.9%).

Only 17 (n=118:14.4%) professional nurses reported that they would like nurse educators to be more visible in the clinical setting. It was felt that nurse educators and professional nurses (9;n=136:6.8%) should both participate in the clinical supervision of nursing students and pupil enrolled nurses. Professional nurses (9;n=118:7.6%)

reported a preference for regular clinical meetings between themselves and the training institution to discuss the on-going development of nursing students and pupil enrolled nurses. It was felt that members of the latter category needed to spend longer periods of time in one clinical department (9;n=118:7.6%) and should be provided with workbooks which contain the clinical outcomes they are supposed to attain in the clinical learning environment (2;n=118:1.7%). Professional nurses (7;n=118:5.9%) suggested that more personnel needed to be appointed in order to better clinical supervision in the SAMHS and that the selection criteria for novice nurses (6;n=118:5.1%) should be reconsidered.

A few professional nurses (5;n=118:4.2%) said that nursing students and pupil enrolled nurses had to be more inquisitive when allocated to a particular clinical setting and that they had to be provided with adequate learning material in an improved, modernised hospital. It was also felt that nurse educators had to supervise nursing students and pupil enrolled nurses on a regular basis (4;n=118:3.4%), with 6 professional nurses (n=118:5.1%) saying that they had provided in-service training to students when these had been allocated to various clinical departments. It was also communicated that the establishment of a clinical department in all the military hospitals could be advantageous and an asset to all nursing categories (5;n=118:4.2%).

It was reported that the appointment of mentors and preceptors (18;n=118:15.3%) in the SAMHS would enhance clinical supervision of nursing students and pupil enrolled nurses. Furthermore, clinical contracts (1;n=118:0.9%) between nurse educators, nursing students and pupil enrolled nurses needed to be drawn up to inform the latter category about the specific outcomes to be achieved. Only 3 (n=118:2.5%) of the professional nurses were of the opinion that nurse educators' clinical knowledge had to be updated and that students needed to be supervised on a daily basis (2;n=118:1.7%) according to a pre-planned roster (2;n=118:1.7%). It was felt that a trusting relationship between nurse educators and students (2;n=118:1.7%) was important for both parties. They were also of the opinion that nursing students and pupil enrolled nurses were not

to be utilised as part of the workforce (2;n=118:1.7%) and that they should receive feedback immediately after the execution of a task or assessment (3;n=118:2.5%). Professional nurses (4;n=118:3.4%) stated a preference that the number of nursing students and pupil enrolled nurses in various clinical departments had to be limited in order to allow them to utilise all the learning opportunities. One (1;n=118:0.9%) of the professional nurses suggested that nursing students and pupil enrolled nurses needed to practice clinical skills on actual patients in the clinical setting and not on mannequins.

Professional nurses recommended that nursing students and pupil enrolled nurses had to take responsibility for their actions in the clinical learning environment (1;n=118:0.9%). Staff shortages had to be avoided in order to prevent using nursing students and pupil enrolled nurses as part of the workforce (1;n=118:0.9%). It was also felt that professional nurses were not to reveal a negative attitude towards students (1;n=118:0.9%). One (n=118:0.9%) of the professional nurses did not have any recommendations for improving clinical supervision in the SAMHS.

Figure 4.69 shows the recommendations of nursing students (NS) and pupil enrolled nurses (PEN) with regard to improving clinical supervision in the SAMHS.

A total of 9 (n=148:6.1%) of the nursing students and pupil enrolled nurses indicated that they were satisfied with clinical supervision in the SAMHS while the same percentage said that they would like to have in service training in the clinical setting at least three times a week. Nursing students and pupil enrolled nurses (5:n=148:3.4%) stated that they would prefer to be assessed by nurse educators on a regular basis. A total of 47 (n=148:31.8%) of the students would like professional nurses and nurse educators to allocate more time to clinical supervision, and 30 (n=148:20.3%) indicated that the latter category had to be visible in the clinical setting.

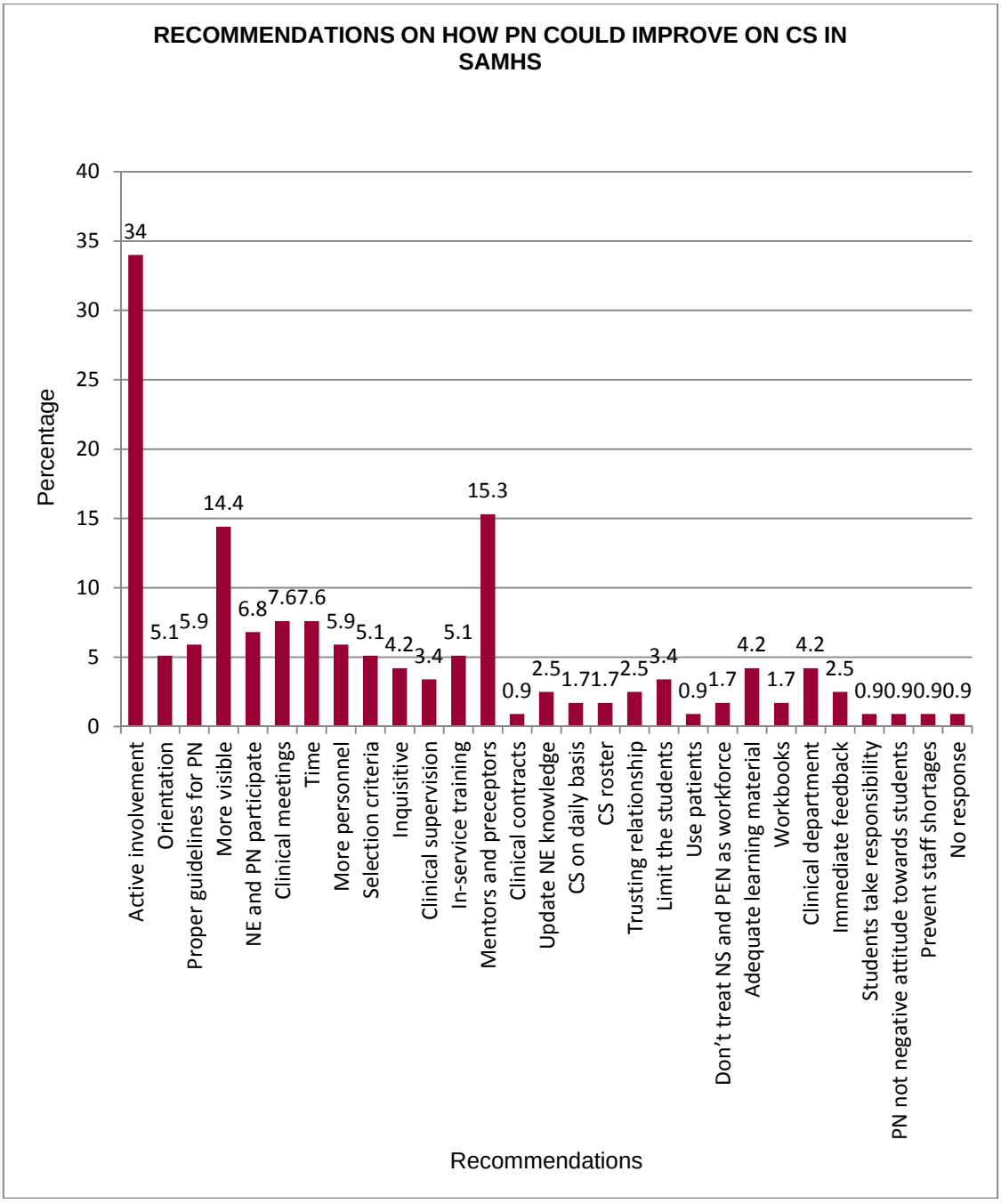

Figure 4.68: Recommendations for how professional nurses (PN) could improve on clinical supervision (CS) in the SAMHS (Section E: Question 2: NE/PN)

Nursing students and pupil enrolled nurses (13;n=148:8.8%) revealed that they had been utilised as part of workforce and therefore attention should be given to the personnel shortage in the clinical setting (17;n=148:11.5%). Only 2 (n=148:1.4%) of the nursing students and pupil enrolled nurses reported that they would like professional

nurses to continue with in-service training in the clinical setting, and 8 (n=148:5.4%) said that the SAMHS had to employ more nurse educators in order to allow them to spend time with students in the clinical setting. Only 9 (n=148:6.1%) of the nursing students and pupil enrolled nurses said that a certain number of nurse educators with the necessary clinical skills (2;n=148:1.4%), needed to be appointed for the supervision of students in the SAMHS. It was felt that this would allow nurse educators to conduct clinical supervision on a continuous basis (1;n=148:0.7%).

It was reported that communication between the training institution and the professional nurses in the clinical setting needed improvement (9:n=148:6.1%). A total of 8 (n=148:5.4%) of the nursing students and pupil enrolled nurses reported that they would like professional nurses to be appointed for the facilitation of clinical supervision. Nursing students and pupil enrolled nurses (3;n=148:2%) indicated that they would like to be paired with and supervised by nursing personnel that have more knowledge. Further more professional nurses in the clinical setting had to take the level of knowledge of nursing students and pupil enrolled nurses into consideration when they delegated nursing tasks (4;n=148:2.7%).

A total of 15 (n=148:10.1%) of the nursing students and pupil enrolled nurses revealed that clinical departments in all the military hospitals needed to be established. The ratio between nurse educators and students needed to be adjusted (2:n=148:1.4%). One respondent (1;n=148:0.7%) reported a preference for more frequent feedback after assessments. Furthermore, it was felt that the availability of transport for nurse educators to the clinical setting in order to assess nursing students needed urgent attention (3;n=148:2%).

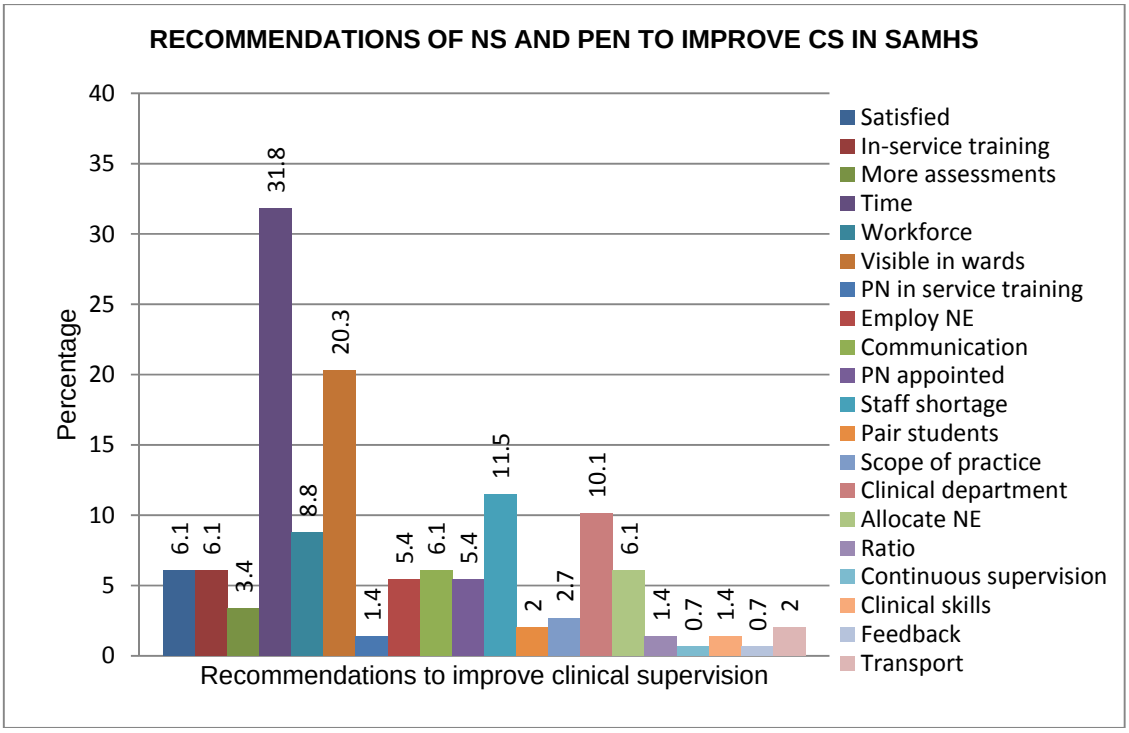

Figure 4.69: Recommendations of nursing students (NS) and pupil enrolled nurses (PEN) improving clinical supervision (CS) in the SAMHS (Section C: Question 4: NS/PEN)

4.7 CONCLUSION

In this chapter the collected data was analysed, interpreted and presented in frequency distribution tables and percentages.

The researcher is convinced that the aim and objectives stated in Chapters 1 and 3 were addressed and that the clinical supervision of nursing students and pupil enrolled nurses in the SAMHS as viewed by nurse educators, professional nurses nursing students and pupil enrolled nurses, has been successfully investigated and described. The recommendations made by all nurse categories as well as the researcher, is described in Chapter 5. Although the recommendations from the final part of the research report, this is considered very important and will provide nurse educators and professional nurse with the necessary guidelines to focus their clinical supervision efforts on crucial matters.

4.8 REFERENCES

BOTMA, Y., GREEFF, M., MULAUDZI, F.M. AND WRIGHT, S.C.D. 2010. Research in health sciences. Cape Town: Pearson.

BRINK, H., VAN DER WALT, C. AND VAN RENSBURG, G. 2008. Fundamentals of research methodology for health care professionals. 2nd ed. Cape Town: Juta & Company.

BURNS, N. AND GROVE, S.K. 2009. The practice of nursing research. 6th ed. Philadelphia: Saunders.

SOUTH AFRICAN NURSING COUNCIL. 2011. Geographical distribution of the population of South Africa versus nursing manpower. Pretoria: Government Printers.

SOUTH AFRICAN NURSING COUNCIL. 1988. *Regulation relating to the approval of and the minimum requirements for the education and training of a nurse (General, Psychiatric and Community) and midwife leading to registration.* Regulation R425 in terms of the Nursing Act, 2005, Act no 33 as amended. Pretoria: Government Printers.

CHAPTER 5

CONCLUSIONS, DISCUSSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Clinical supervision is the means by which clinical supervisors utilise clinical knowledge and experience to assist nursing students to develop their knowledge, competence, values and practices (Gopee, 2008:9).

In this chapter the researcher makes various recommendations based on the scientific evidence obtained from the study after an evaluation of the views of the different nursing categories on clinical supervision in the SAMHS. Recommendations were made to the nursing management and the principals of the different nursing colleges, and mainly focused on the enhancement of clinical supervision in the SAMHS. If these recommendations are put into practice this should have a positive effect on the quality of patient care in South Africa.

The objectives of the research study as listed in paragraph 1.4 were achieved through a scientific evaluation of the views of the different nursing categories on clinical supervision in the SAMHS.

The recommendations formulated by the researcher are based on the points of departure, namely that nurse educators and professional nurses are role models and mentors for nursing students and pupil enrolled nurses (cf. Gopee, 2008:23; Stuart, 2004:194). This relationship is regarded as critical for the latter category to acquire the theoretical knowledge, practical skills (cf. Gopee, 2008:9), necessary attitudes and judgement needed to provide safe and competent care (cf. Mellish, Brink and Paton, 2008:210). Furthermore, clinical supervision of nursing students and pupil enrolled nurses forms the key element of an approved nursing education programme (cf. Lynch, Hancox, Happel and Parker, 2008:5).

The following results were scientifically obtained from the research.

5.2 CONCLUSIONS, DISCUSSIONS AND RECOMMENDATIONS

5.2.1 Facilitation of clinical supervision by nurse educators and professional nurses

It was determined that clinical supervision by nurse educators and professional nurses in the SAMHS was not being facilitated as required by the South African Nursing Council (SANC R425 of 22 February 1985, as amended), as shown in Figures 4.3 and 4.4. Despite the fact that nurse educators and professional nurses indicated that the majority of nurse educators and professional nurses spent enough time with nursing students and pupil enrolled nurses, the latter category disagreed.

The Strategic Plan for Nursing Education, Training and Practice (2012/13-2016/17:17) stipulates that the supervision and management of students is inadequate and that overall, these students require first-class clinical role models. Currently the correlation between the skills and competencies of nurse educators and professional nurses in the clinical learning environment is non-existent. This situation is aggravated by deficient communication between the nursing education sector and practice. Research conducted on the capability of newly qualified nurses to practice autonomously in various clinical settings, has concluded that students are not satisfied with their clinical supervision because they do not have positive role models, are not applying theory learned in practice, are experiencing high levels of stress and are unprepared for the execution of their roles (Strategic Plan for Nursing Education, Training and Practice 2012/13-2016/17:17).

5.2.1.1 Recommendation 1: Supervision

- The clinical supervision of nursing students and pupil enrolled nurses by nurse educators and professional nurses in the SAMHS should be prioritised and both

categories, i.e. nurse educators and professional nurses, should take responsibility for teaching students the roles and responsibilities of professional nurses and enrolled nurses. The appointment of mentors in the military clinical environment could allow students to enjoy supernumerary status, while supported and supervised by professional nurses acting as mentors.

5.2.2 Aspects inhibiting nurse educators and professional nurses from facilitating clinical supervision

Figures 4.13 to 4.20 reveal that the majority of nursing students and pupil enrolled nurses were more likely to agree that lecturing duties inhibited nurse educators from facilitating clinical supervision. Furthermore, staff shortages and a heavy workload constituted factors that increased nursing staff stress and complicated the efforts of professional nurses to support student learning in the clinical environment.

Nurse educators are confronted with numerous challenges such as inadequate numbers, the absence of orientation programmes, heavy workloads due to high nurse educator-student ratios, insufficient professional development with regard to knowledge and skills and up-skilling in new technologies. All these factors impact negatively on the quality of the teaching and clinical supervision of students (Strategic Plan for Nurse Education, Training and Practice 2012/13-2016/17:18). Hence nurse educators and professional nurses are forced to compromise on their supervisory role.

5.2.2.1 Recommendation 2: Clinical mentors and preceptors

- The appointment of clinical mentors and preceptors in the SAMHS could provide practitioners to oversee the education and training of nursing students and pupil enrolled nurses when they are allocated to the clinical setting. Clinical mentors and preceptors could also support nursing students and pupil enrolled nurses in their professional development and could be responsive to students' learning needs. The SAMHS could support the mentor and preceptor process by offering

educational programmes and coaching for mentor and preceptor development. Mentors and preceptors could receive compensation for assuming this additional responsibility.

5.2.3 Establishment of a clinical department

As shown in Figure 4.26, a need was identified for urgent attention to be paid to the establishment of a clinical department in each of the military hospitals in order to try and accomplish uniformity in the military clinical environment. It was also reported that recently qualified nurses encounter major challenges when entering clinical practice. Thus it was felt that clinical education and training needs to be reinforced through the re-establishment of clinical teaching departments at all nursing education institutions or hospitals. This endeavour must be underpinned by a co-ordinated system of clinical preceptors and supervisors in a designated clinical teaching department (Strategic Plan for Nursing Education, Training and Practice 2012/13-2016/17:28).

5.2.3.1 Recommendation 3: Clinical departments

- With the establishment of clinical departments in the various military hospitals, liaison between the clinical departments will ensure that there is uniformity across all hospitals regarding the execution of clinical procedures and working methods, which is not currently the case. The researcher recommends that this situation be treated as a matter of urgency.

5.2.4 Joint responsibility for the teaching, learning and development of students

Figures 4.23 to 4.25 shows that the majority of respondents agreed that nurse educators and professional nurses have a joint responsibility for the facilitation of clinical supervision in the SAMHS.

According to the Strategic Plan for Nursing Education, Training and Practice (2012/13-2016/17:74), nurse educators and professional nurses have clear roles and responsibilities that jointly support and enhance students' clinical learning experiences. The responsibilities that are outlined for nurse educators entail the maintenance of clinical competence through spending, annually 10% teaching time in the clinical setting in relation with the subject being taught. Furthermore, they need to supervise and support preceptors. Professional nurses are also required to work closely with clinical preceptors and nurse educators regarding the clinical teaching and supervision of students allocated to their departments.

5.2.4.1 Recommendation 4: Joint responsibility

- The clinical responsibilities relating to the teaching and learning of nursing students and pupil enrolled nurses should be shared between nurse educators and professional nurses as substantiated in paragraph 2.3.1. The nurse educator needs to belong to both the clinical and educational worlds and must be ideally placed to promote a correlation between theory and practice. In this way learning can be facilitated through the creation of nurse educator-practitioner posts.

5.2.5 Support in the clinical setting

An overwhelming majority of the nursing students and pupil enrolled nurses agreed that the clinical supervision rendered in the SAMHS was not sufficiently supportive for the learning and development of professional– and practical skills, as shown in Figure 4.30.

Certain components in the clinical learning environment which strengthen and support nursing personnel and exercise a positive impact on patient outcomes and organisational cost-effectiveness, could assist in the delivery, creation and maintenance of an effective nursing workforce. This could help to create quality health systems of a high standard (Strategic Plan for Nursing Education, Training and Practice 2012/13-

2016/17:38). If nursing students and pupil enrolled nurses are to flourish, they have to be well supported by the training institution, (Linsley, Kane, McKinnon, Spencer and Simpson, 2008:173; Mabuda, Potgieter and Alberts, 2008:23; Vallant and Neville, 2006:24; Waldock, 2010:2) professional nurses, peers and colleagues (Vallant and Neville, 2006:24; Warren, 2010:1364).

5.2.5.1 Recommendation 5: Support in the clinical setting

- The support of nursing students and pupil enrolled nurses in the clinical setting is critical if the SAMHS is to ensure that nursing education programmes are producing competent nurses able to function in an ever-changing environment. A heavy workload and staff shortages in the clinical learning environment prevents nurse educators and professional nurses from supporting nursing students and pupil enrolled nurses, and thus necessitating the appointment of mentors and preceptors in the military health environment.

5.2.6 Distribution of a structured clinical supervision programme

As identified in Figure 4.41, a need was reported for a clinical structured supervision programme to guide nursing students and pupil enrolled nurses in the clinical setting.

The main objective of nursing education and training is to provide sufficient numbers of skilled, knowledgeable and caring nurses in order to meet the health needs of the country. Therefore nursing education and training programmes should coordinate with health service delivery while safeguarding the professional qualifications obtained corresponding with the scopes of practice and relevant legislation (Strategic Plan for Nursing Education, Training and Practice 2012/13-2016/17:28).

5.2.6.1 Recommendation 6: Structured clinical supervision programme

- It is recommended that nurse educators provide professional nurses in the clinical setting with a structured clinical supervision programme. This could facilitate teaching and learning in the clinical environment (Mochaki, 2007:32). Nursing students and pupil enrolled nurses' expectations and requirements could be met in this way, practical skills could be enhanced and learning outcomes could be achieved.

5.2.7 Verbal agreement or a formal written contract between nurse educators and students

As shown in Figures 4.52 and 4.53, the vast majority of nursing students and pupil enrolled nurses agreed that there is a verbal agreement between themselves and nurse educators.

5.2.7.1 Recommendation 7: Contractual agreement

- The researcher recommends that a formal written contract, better known as a clinical supervision agreement, needs to be drawn up between nurse educators and students. The agreement should offer a written explanation of mutually understood expectations of the process, approved by both parties. This contract has to provide background information on clinical supervision and must include the foundations, framework, over all structure (e.g. ground rules), practical details, expectations, confidentiality, respect and frequency of clinical supervision (cf. Lynch et al., 2008:190).

5.2.8 Allocate students according to their knowledge and level of training

Figure 4.55 shows that the majority of students were of the opinion that professional nurses did not allocate them to the clinical learning environment according to their level of training.

According to Meyer and Van Niekerk (2008:108) the responsibility providing students with the general and clinical outcomes for the specific clinical setting, remains with the nurse educators, as does compliance with the requirements of the clinical experience and the methods of clinical evaluation and written graded criteria.

5.2.8.1 Recommendation 8: Allocation and level of training

- Nurse educators in the SAMHS should provide professional nurses with the outcomes and learning experiences that students have to achieve in the different clinical departments. The different requirements should be discussed with the professional nurse. Follow-up sessions should be scheduled to ensure that these requirements are met. This strategy should simplify matters for professional nurses and enable them to allocate students according to their level of knowledge and training.

5.2.9 Students utilised as part of workforce in the clinical setting

As shown in Figure 4.56, the research identified that students strongly agreed that they were being utilised as part of workforce in the SAMHS.

Because of the busy and demanding nature of the clinical environment the supernumerary status of students is forgotten in the clinical setting (Allan, Smith and O'Driscoll, 2011:850; Waldock, 2010:16). Students should not experience the clinical component of the teaching-learning programme as "work", but rather as an opportunity for developing their professional and personal skills whilst caring for patients.

5.2.9.1 Recommendation 9: Supernumerary status and students

- The nurse educator in the SAMHS has the responsibility of correcting this situation and placing greater emphasis on the educational needs of students.

5.2.10 Nurse educator and student ratio

Figure 4.8 shows that one of the factors that inhibiting nurse educators from spending time with students in the clinical learning environment, is the ratio between these two categories.

Due to the decreased involvement of professional nurses in teaching and supervision in the clinical environment, larger nurse educator-student ratios are experienced. Global standards recommend groups of not more than 15 and preferably nurse educator to student ratios of 1:15-20 for pre-registration clinical training and supervision (Strategic Plan for Nursing Education, Training and Practice 2012/13-2016/17:74).

5.2.10.1 Recommendation 10: Educator-student ratios

- An investigation into the nurse educator-student ratio in the SAMHS needs to be conducted. It is recommended that, if needed, the number of nurse educators be adjusted based on the findings of the investigation. The management structures of each institution for nurse training should be responsible for driving this process.

5.2.11 Transport availability

Clinical facilities are geographically distant from the main campus in Thaba Tshwane and this it is a deterrent in nurse educators' clinical supervision of students as shown in Figure 4.57.

Health service delivery challenges identified by the Ministerial Task Team on Nursing Education and Training comprise infrastructure and resource shortages, inaccessibility of clinical facilities because of distances between education, training and clinical facilities lack of transport, a shortage of nurse educators to supervise students, as well as shortage of nurse accommodation and demonstration rooms (Strategic Plan for Nursing Education, Training and Practice 2012/13-2016/17:18).

5.2.11.1 Recommendation 11: Transportation

- To overcome the transport problem the researcher recommends that a roster be drawn up with planned trips to the clinical facility. Nurse educators should plan their daily activities and clinical supervision according to the available roster. The availability of military transport and a duty driver are necessary for assisting nurse educators to reach distant clinical facilities. Visits to the clinical area could not only promote clinical supervision in the SAMHS but also ensure that clinical outcomes are achieved as substantiated in the conceptual framework in paragraph 1.5.

5.3 CONCLUSION

The ability of the SAMHS to offer distinctive learning opportunities and support for nursing students and pupil enrolled nurses, and the ability to ensure that nursing students experience professional development positively, depends on how well the eleven recommendations made by the researcher are addressed. It is vital that these recommendations be discussed with all the stakeholders. A strategic plan should be made available, implemented and monitored through the involvement of the relevant management structures. Actions taken could ensure that students in the SAMHS acquire the necessary competencies for professional practice in a clinical learning environment that is conducive to their development.

5.4 REFERENCES

ALLAN, H.T., SMITH, P. AND O'DRISCOLL, M. 2011. Experiences of supernumerary status and the hidden curriculum in nursing: A new twist in the theory-practice gap? *Journal of Clinical Nursing*, 20(5):847-855.

ALLEN, B. 2008. Mind the gap. British Journal of School Nursing, 3(3):133-135.

ANDREWS, G.J., BRODIE, D.A., ANDREWS, J.P., HILLAN, E., THOMAS, B.G., WONG,J. AND RIXON, L. 2006. Professional roles and communications in clinical placements: A qualitative study of nursing students' perceptions and some models for practice. *International Journal of Nursing Studies*, 43(7):861-874.

BRAMMER, J.D. 2008. RN as gatekeeper: Gatekeeper as monitoring and supervision. *Journal of Clinical Nursing*, 17(14):1868-1872.

BRYANT, L. 2010. Clinical supervision. Practice nurse, 39(12):36-41.

ELLIS, M.V. 2010. Bridging the science and practice of clinical supervision: Some discoveries, some misconceptions. *The Clinical Supervisor*, 29(1):95-116.

FRANKEL, A. 2008**.** Applying theory to practice through clinical supervision. *Nursing times*, [n.d.].

GOPEE, N. 2008. Mentoring and supervision in healthcare. Great Britain: SAGE.

HENDERSON, A., FOX, R. AND MALKO-NYHAN, K. 2006. An evaluation of preceptors' perceptions of educational preparation and organizational support for their role. *Journal of Continuing Education in Nursing*, 37(3):130-136.

JIANG, R., CHOU, C. AND TSAI, P. 2012. Preceptor-guided clinical practica and the learning experiences of nursing students. The Journal of Nursing Research, 20(2):152-157.

KEMPER, N.J. 2007. Win-win strategies help relieve preceptor burden. *Nursing Management*, 38(2):10-12.

LINSLEY, P., KANE, R., McKINNON, J., SPENCER, R. AND SIMPSON, T. 2008. Preparing for the future: Nurse education and workforce development. *Quality in Primary Care*, 16(3):171-176.

LYNCH, L., HANCOX, K., HAPPELL, B. AND PARKER, J. 2008. Clinical supervision for nurses. Singapore: Wiley.

MABUDA, B.T., POTGIETER, E. AND ALBERTS, U.U. 2008. Student nurses' experiences during clinical practice in the Limpopo Province. *Curationis*, 31(1):19-27.

MELLISH, J.M., BRINK, H.I.L AND PATON, F. 2008. Teaching and learning the practice of nursing. 4th ed. Sandton: Heinemann.

MEYER, S. AND VAN NIEKERK, S. 2008. Nurse educator in practice. Cape Town: Juta & Company.

MCGOWAN, B. 2006. Who do they think they are? Undergraduate perceptions of the definition of supernumerary status and how it works in practice. *Journal of Clinical Nursing*, 15(9):1099-1105.

MOCHAKI, N.W. 2007. Real learning. *Nursing Update*, 31(2): 32-35.

SOUTH AFRICA. Department of Health. 2012. Strategic Plan for Nursing Education, Training and Practice 2012/2013-2016/17. Summary document: A long and healthy life for all South Africans. Pretoria: Government Printers.

SOUTH AFRICAN NURSING COUNCIL. 1985. Approval of and minimum requirements for education and training of a nurse (general, psychiatric and ommunity) and midwife leading to registration. Regulation R425 of 22 February 1985 as amended. Pretoria: Government Printers.

STUART, C.C. 2004. Assessment, supervision and support in clinical practice. China: Churchill Livingstone.

TAYLOR, C. 2009. Mutually supportive. *Nursing Standard*, 24(1):61.

VALLANT, S. AND NEVILLE, S. 2006. The relationship between student nurse and nurse clinician: Impact on student learning. *Nursing Praxis in New Zealand*, 22(3):23-33.

WALDOCK, J. 2010. Facilitating student learning in clinical practice. *Kai Tiaki nursing New Zealand*, 16(1):14-16.

WARREN, D. 2010. Facilitating pre-registration nurse learning: A mentor approach. *British Journal of Nursing*, 19(21):1364-1367.

ANNEXURE A

COVERPAGE: RESPONDENTS

INFORMATION DOCUMENT FOR RESPONDENTS

(Nurse educators, Professional nurses, Nursing students and Pupil enrolled nurses)

CLINICAL SUPERVISION OF NURSING STUDENTS AND PUPIL ENROLLED NURSES IN THE SOUTH AFRICAN MILITARY HEALTH SERVICE (SAMHS)

You are selected to participate voluntarily in this research study that will be conducted at 1, 2 and 3 Military Hospitals as well as at the Nursing Colleges at various Military Hospitals.

The aim of the research study is to describe the opinions of Nurse Educators, Professional Nurses, Nursing Students and Pupil Enrolled Nurses regarding clinical supervision in the Military Health Service.

As a respondent you will be requested to answer questions on a questionnaire that will take approximately 30 minutes to complete. The information on a complete questionnaire will remain anonymous and confidential. Your identity will be protected and not revealed throughout the research study. Data gathered will not be made available to any unauthorised person. The final results of the research study will be published in a scientific journal through the School of Nursing, University Free State.

The research study does not entail any physical injuries. Should you experience uneasiness at any stage during completion of the questionnaire, feel free to discuss it with the researcher. Withdrawal from the research study can be done at any time of the study. Communicate your decision to withdraw from the research study to the researcher involved. You will not be discriminated against if you refuse to participate or decide to terminate participation.

There are no financial obligations for respondents participating in this research study. The service rendered by the researcher is free of charge.

Potential benefits for all respondents of this research study are excluded, but the valuable information gathered from your participation will be utilised in future clinical supervision of nursing students and pupil enrolled nurses in the military milieu.

No monetary funding involved for respondents. Seeing that the completion of the questionnaire will be conducted whilst on duty, travel expenses and inconvenience allowances will not be paid.

If you have any uncertainties or questions about the research study, feel free to contact Me A. Coetzee at the following numbers: 051 402 1850 or 083 234 3812.

I have read the information and understood the content of the consent form. All questions that I had about the research study have been answered to my satisfaction. I hereby give voluntarily consent to participate in this research study.

ANNEXURE B

QUESTIONNAIRE: NURSE EDUCATORS AND PROFESSIONAL NURSES

QUESTIONNAIRE

Dear respondent

You have been asked to participate in a research study. Please note that by completing this questionnaire you are voluntarily agreeing to participate in this research study. You will remain anonymous and your data will be treated confidentially at all times. You may withdraw from this study at any given moment during the completion of the questionnaire. The results of the study may be published.

CLINICAL SUPERVISION OF
NURSING STUDENTS AND PUPIL ENROLLED NURSES IN THE SOUTH AFRICAN MILITARY HEALTH SERVICES (SAMHS)

Nurse Educators and Professional Nurses

INSTRUCTIONS:

The questionnaire is designed to describe the opinions of nurse educators and professional nurses regarding clinical supervision of nursing students and pupil enrolled nurses in the South African Military Health Service.

Please answer all applicable questions as complete as possible. Note that there is no right or wrong answer. Be honest in the completion of the questionnaire and do not discuss your answers with anyone.

Complete the questionnaire by placing a [X] in the block next to the question. Open-ended questions can be answered in the space provided.

Nurse educators who supervise:

- **nursing students**, complete **Section A**, **B** and **D.**
- **pupil enrolled nurses**, complete **Section A**, **C** and **D.**

Professional nurses who supervise:

- **nursing students**, complete **Section A**, **B** and **E.**
- **pupil enrolled nurses**, complete **Section A, C and E.**

FOR OFFICE USE

			1-3

SECTION A

DEMOGRAPHIC DATA

1. Indicate your gender.

Male	1
Female	2

	4

2. Write your age in years. _____

		5-6

3. Tick the box next to the hospital/nursing college where you are working.

1 Military Hospital	1
2 Military Hospital	2
3 Military Hospital	3
Nursing College Thaba Tshwane	4
Nursing College Bloemfontein	5
Nursing College Cape Town	6

	7

4. Write the years of service you have in the present hospital/ nursing college. _____

		8-9

5. Indicate the position you are appointed in.

Nurse educator	1
Professional nurse	2

	10

6. Indicate the nursing category that you supervise in the clinical setting.

Nursing students	1
Pupil enrolled nurses	2

	11

SECTION B

CLINICAL SUPERVISION BY NURSE EDUCATORS AND PROFESSIONAL NURSES

1. Indicate the amount of time you have spent more or less per month **per nursing student** in the last four months on clinical supervision.

	2011			
	January	**February**	**March**	**April**
1.1 None				
1.2 Less than half an hour				
1.3 More than half an hour but less than one hour				
1.4 More than an hour but less than two hours				
1.5 More than two hours				

J F M A

☐☐☐☐ 12-15

☐☐☐☐ 16-19

☐☐☐☐ 20-23

☐☐☐☐ 24-27

☐☐☐☐ 28-31

2. If you did spend less than half an hour (or no time) on clinical supervision in the clinical setting per month **per nursing student**, what are your reason(s)?

January: _____

_____ ☐☐ 32-33

February: _____

_____ ☐☐ 34-35

March: _____

_____ ☐☐ 36-37

April: _____

_____ ☐☐ 38-39

3. Who, according to you, should be responsible for the clinical supervision of **nursing students**?

Nurse educators	1
Professional nurses	2
Both categories	3
Preceptors or mentors	4

☐ 40

4. Motivate your answer to question 3.

_____

_____

_____

_____ 41-42

_____ 43-44

_____ 45-46

5. List the suggestions you have with regard to the clinical supervision of **nursing students**.

_____

_____

_____

_____ 47-48

_____ 49-50

_____ 51-52

6. In general what influenced the time you spent on clinical supervision with **nursing students**?

_____

_____

_____

_____ 53-54

_____ 55-56

_____ 57-58

SECTION C

CLINICAL SUPERVISION BY NURSE EDUCATORS AND PROFESSIONAL NURSES

1. Indicate the amount of time you have spent more or less per month **per pupil enrolled nurse** in the last four months on clinical supervision.

	2011			
	January	**February**	**March**	**April**
1.1 None				
1.2 Less than half an hour				
1.3 More than half an hour but less than one hour				
1.4 More than an hour but less than two hours				
1.5 More than two hours				

2. Indicate the reason(s) why you spend less than half an hour **per pupil enrolled nurse** per month in the clinical setting.

January: _____

_____

February: _____

_____

March:_____

_____

April: _____

_____

3. In general what influenced the time you spent on clinical supervision with **pupil enrolled nurses**?

_____

_____

J F M A

59-62

63-66

67-70

71-74

75-78

79-80

1-2

3-4

5-6

_____ 7-8

_____ 9-10

_____ 11-12

_____

4. Who, according to you, should be responsible for clinical supervision of **pupil enrolled nurses**?

Nurse educators	1
Professional Nurses	2
Both categories	3
Preceptors or mentors	4

13

5. Motivate your answer to question 4.

_____

_____

_____

_____ 14-15

_____ 16-17

_____ 18-19

6. List your suggestions with regard to the clinical supervision of **pupil enrolled nurses**.

_____

_____

_____

_____ 20-21

_____ 22-23

_____ 24-25

SECTION D

ROLES AND RESPONSIBILITIES OF NURSE EDUCATORS IN THE CLINICAL SETTING

INSTRUCTIONS

Mark the category (nursing student **OR** pupil enrolled nurse) that you supervise in the clinical setting.

Each statement has to be marked only once (see example below).

EXAMPLE:

If you are a nurse educator who supervises nursing students:

- read the statement
- decide whether you: * strongly agree
  * agree
  * disagree
  * strongly disagree
- mark the block underneath the category that you supervise in the clinical setting

STATEMENTS	1 Strongly agree		2 Agree		3 Disagree		4 Strongly disagree	
	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED N URSE	NURSING STUDENT	PUPIL ENROLLED NURSE
In case of the following category, nurse educators:								
e.g. Give adequate support in the clinical setting			X					

1. **Nurse educators** indicate your answers on the following statements:

STATEMENTS	1 Strongly agree		2 Agree		3 Disagree		4 Strongly disagree		
	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	
In case of the following category, nurse educators:									
In case of the following category, nurse educators:									
1.10 Plan placement dates before allocation in the clinical setting									35
1.1 Give adequate support in the clinical setting									
1.11 Disclose placement areas before allocation in the clinical setting									36
1.2 Do not experience tension between the execution of daily routine tasks and clinical supervision									
1.12 Do not provide professional nurses with structured clinical supervision skills programme									37
1.3 Are competent to teach up-to-date clinical skills									
1.4 Meet the learning needs in specific clinical placement areas									
1.13 Are involved with the assessment of clinical competence									38
1.5 Plan learning activities that are in line with the educational requirements at different levels of training.									
1.6 Have the task to train professional nurses with regard to clinical supervision									
1.7 Do not have effective communication with professional nurses with regard to learning outcomes									
1.8 Communication with regard to learning outcomes are effective									
1.9 Give immediate feedback after completion of a task									

2. List your recommendations to improve clinical supervision.

_____

_____

_____

_____

_____

_____

_____

_____

		39-40
		41-42
		43-44

SECTION E

ROLES AND RESPONSIBILITIES OF PROFESSIONAL NURSES IN THE CLINICAL SETTING

INSTRUCTIONS

Mark the category (nursing student **OR** pupil enrolled nurse) that you supervise in the clinical setting.

Each statement has to be marked only once (see example below).

EXAMPLE:

If you are a professional nurse who supervises nursing students:

- read the statement
- decide whether you: * strongly agree
  * agree
  * disagree
  * strongly disagree
- mark the block underneath the category that you supervise in the clinical setting

STATEMENTS	1 Strongly agree		2 Agree		3 Disagree		4 Strongly disagree	
	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED N URSE	NURSING STUDENT	PUPIL ENROLLED NURSE
In case of the following category, professional nurses:								
e.g. Give adequate support in the clinical setting			X					

1. **Professional nurses** indicate your answers on the following statements:

STATEMENTS	1 Strongly agree		2 Agree		3 Disagree		4 Strongly disagree		
	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	
In case of the following category, professional nurses:									
1.1 Give adequate support in the clinical setting									45
1.2 Do not experience tension between the execution of daily routine tasks and clinical supervision									46
1.3 Are competent to teach up-to-date clinical skills									47
1.4 Meet the learning needs in specific clinical placement areas									48
1.5 Are required to incorporate the									

responsibility of clinical supervision in their already busy workload										49
1.6 See their presence as an added burden										50
1.7 Have no interest in their clinical supervision										51
1.8 Feel that recognition by nurse educators would emphasize the value of their contribution to student education										52
1.9 Take responsibility for their clinical supervision supported by nurse educators located elsewhere										53

2. List your recommendations to improve clinical supervision.

_____

_____

_____

_____

_____

_____

_____

_____

		54-55
		56-57
		58-59

THANK YOU FOR YOUR PARTICIPATION!

ANNEXURE C

QUESTIONNAIRE: NURSING STUDENTS AND PUPIL ENROLLED NURSES

QUESTIONNAIRE

Dear respondent

You have been asked to participate in a research study. Please note that by completing this questionnaire you are voluntarily agreeing to participate in this research study. You will remain anonymous and your data will be treated confidentially at all times. You may withdraw from this study at any given moment during the completion of the questionnaire. The results of the study may be published.

CLINICAL SUPERVISION OF
NURSING STUDENTS AND PUPIL ENROLLED NURSES IN THE SOUTH AFRICAN MILITARY HEALTH SERVICE (SAMHS)

Nursing Students and Pupil Enrolled Nurses

The questionnaire is designed to describe the opinions of nursing students and pupil enrolled nurses regarding clinical supervision in the South African Military Health Service.

Please answer all applicable questions as complete as possible. Note that there is no right or wrong answer. Be honest in the completion of the questionnaire and do not discuss your answers with anyone.

Complete the questionnaire by placing a [X] in the block next to the question. Open-ended questions can be answered in the space provided.

Nursing students:

- Complete **Section A**, **B** and **C.**

Pupil enrolled nurses:

- Complete **Section A, B and C.**

FOR OFFICE USE

SECTION A | | | | 1-3

DEMOGRAPHIC DATA

1. Indicate your gender.

Male	1
Female	2

	4

2. Write your age in years. _____ | | | 5-6

3. Tick the box next to the hospital where you do your clinical practica.

1 Military Hospital	1
2 Military Hospital	2
3 Military Hospital	3

	7

4. Tick the box next to the nursing college where you attend theoretical classes.

Nursing College Thaba Tshwane	1
Nursing College Bloemfontein	2
Nursing College Cape Town	3

	8

5. Write down the years of service you have in the SAMHS _____ | | | 9-10

6. Indicate the position that you are appointed in.

Nursing student (Diploma)	1
Pupil enrolled nurse	2

11

SECTION B

CLINICAL SUPERVISION OF NURSING STUDENTS AND PUPIL ENROLLED NURSES

1. Indicate per month the amount of time the **nurse educator** spent more or less with you on clinical supervision.

	2011			
	January	**February**	**March**	**April**
1.1 None				
1.2 Less than half an hour				
1.3 More than half an hour but less than an hour				
1.4 More than an hour but less than two hours				
1.5 More than two hours				

J F M A

15

16-19

20-23

24-27

28-31

2. If less than half an hour (or none) indicate the reason(s) why you think the **nurse educator** spent so little time with you in the clinical setting.

January: _____

32-33

_____

February: _____ 34-35

_____

March: _____ 36-37

_____

April: _____ 38-39

_____

3. Indicate per month the amount of time the **professional nurse** spent more or less with you on clinical supervision.

	2011			
	January	**February**	**March**	**April**
3.1 None				
3.2 Less than half an hour				
3.3 More than half an hour but less than an hour				
3.4 More than an hour but less than two hours				
3.5 More than two hours				

J F M A

40-43

44-47

48-51

52-55

56-59

4. If less than half an hour (or none) indicate the reason(s) why you think the **professional nurse** spent so little time with you in the clinical setting.

January: _____ 60-61

_____

February: _____ 62-63

_____

March: _____ 64-65

_____

April: _____ 66-67

_____

5. In general what do you think influenced the time that the **nurse educator** spent on clinical supervision?

_____

_____

_____

_____

_____ 68-69

_____ 70-71

_____ 72-73

6. In general what do you think influenced the time that the **professional nurse** spent on clinical supervision?

_____

_____

_____

_____

_____ 74-75

_____ 76-77

_____ 78-79

SECTION C

ROLES AND RESPONSIBILITIES OF NURSE EDUCATORS AND PROFESSIONAL NURSES IN CLINICAL SUPERVISION

INSTRUCTIONS:

Nursing students **and** pupil enrolled nurses must answer **all** the statements.

Each statement needs to be marked once in order to represent your category (see example below).

EXAMPLE:

If you are a **pupil enrolled nurse**:

- read the statement
- decide whether you: * strongly agree
  * agree
  * disagree
  * strongly disagree
- mark the block underneath the category that you represent

STATEMENTS	1 Strongly agree		2 Agree		3 Disagree		4 Strongly disagree	
	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE
In case of the following category, nurse educators:								
e.g. Give adequate support in the clinical setting				X				

1. **Nursing students and pupil enrolled nurses** indicate your answers on the following statements:

STATEMENTS	1 Strongly agree		2 Agree		3 Disagree		4 Strongly disagree		
	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	
In case of the following category, nurse educators:									
1.1 Experience clinical supervision as an inconvenience									80
1.2 Experience clinical supervision as time consuming									1
1.3 Are only seen in the clinical setting when they have to evaluate									2
1.4 Are competent to teach up-to-date clinical skills									3
1.5 Have knowledge with regard to clinical skills									4
1.6 Have a formal agreement /contract with learners									5
1.7 Have a verbal agreement /contract with learners									6
1.8 Render inadequate support in the clinical setting									7
1.9 Provide regular feedback to learners regarding performance									8
1.10 Need to work alongside learners to demonstrate how they can integrate theory and practice									9

2. **Nursing students and pupil enrolled nurses** indicate your answers on the following statements:

STATEMENTS	1 Strongly agree		2 Agree		3 Disagree		4 Strongly disagree		
	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	
In case of the following category, professional nurses:									
2.1 Experience clinical supervision as an inconvenience (e.g. time consuming)									10
2.2 Do not allocate nursing care to learners according to their level of training									11
2.3 Are not in favour of releasing learners to attend clinical supervision sessions because they serve as working force									12
2.4 Give appropriate guidance to learners, therefore they need not to look to other peers for guidance									13
2.5 Do not have a teaching function									14

3. **Nursing students and pupil enrolled nurses** indicate your answers on the following statements:

STATEMENTS	1 Strongly agree		2 Agree		3 Disagree		4 Strongly disagree		
	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	
General: I think that:									
3.1 A heavy workload in the clinical setting limit the opportunities for proper teaching and guidance									15
3.2 A staff shortage limit the opportunities for proper teaching and guidance during clinical supervision in the clinical environment									16
3.3 I will have adequate clinical skills upon completion of my education and training									17
3.4 I do not get adequate clinical supervision because it is assumed that I know most of the work									18
3.5 Communication between the academic institution and the clinical setting is adequate									19
3.6 The clinical learning environment provides adequate learning experiences									20
3.7 Supervision sessions are done in isolation (e.g. previous sessions not considered)									21
3.8 Strong evidence exist of discrepancy between classroom theory and the learning that takes place in the clinical setting									22

STATEMENTS	1 Strongly agree		2 Agree		3 Disagree		4 Strongly disagree		
	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	NURSING STUDENT	PUPIL ENROLLED NURSE	
General: I think that:									
3.9 Clinical supervision offers me the opportunity to learn without fear of embarrassment from making mistakes									23
3.10 Clinical supervision is inadequate									24

4. List your recommendations to improve clinical supervision.

_____ 25-26

_____

_____

_____

_____ 27-28

_____

_____ 29-

30

THANK YOU FOR YOUR PARTICIPATION!

ANNEXURE D

LETTERS: PERMISSION TO CONDUCT RESEARCH

CONFIDENTIAL

3MH/C/94706819PE

Telephone: 051 4021850
Facsimile: 051 4021877
Enquiries: Maj A. Coetzee

SAMHS Nursing College
Bloemfontein
Private Bag X40003
Brandhof
9324

19 January 2011

Director Nursing
Department of Defence
SAMHS Office
Private Bag X102
Centurion
0046

REQUESTING PERMISSION TO CONDUCT RESEARCH STUDY IN THE MILITARY HEALTH SERVICES: 94706819PE MAJ A. COETZEE

1. I would like to request permission to conduct a research study in the Military Health Services. The research study forms part of the Masters Dissertation I am presently enrolled for at the University of the Free State. Approval from the Expert, Evaluation and Ethical committee of the Faculty of Health Sciences will be obtained before commencement of the research study.

2. I am currently employed by the South African Military Health Services as a facilitator at the Nursing College in Bloemfontein.

3. The aim of the proposed study is to describe clinical supervision of nursing students and pupil enrolled nurses in the South African Military Health Services.

CONFIDENTIAL

4. Thank you for your highly appreciated assistance in this regard!

A Coetzee (MAJ)
(A. COETZEE)
FACILITATOR SAMHS NURSING COLLEGE BLOEMFONTEIN: MAJ

Remarks:
The study will be of benefit to nursing education and therefore excellent patient care.

Lt Col
(P.M. MOTSEKI)
OFFICER IN CHARGE SAMHS NURSING COLLEGE BLOEMFONTEIN: LT COL

19/07/2009 18:09 0126715017 SAMHS PTSR NODAL PAGE 04/04

CONFIDENTIAL

3

Remarks:

Research request is recommended provided policy of such a request is followed.

pp (E.M. JOSEPH) 20/01/2011
DIRECTOR NURSING: BRIG GENL
as instructed

CONFIDENTIAL

Col Mabuza

CONFIDENTIAL

3MH/C/94706819PE

Telephone: 051 4021850
Facsimile: 051 4021877
Enquiries: Maj A. Coetzee

SAMHS Nursing College
Bloemfontein
Private Bag X40003
Brandhof
9324

19 January 2011

The Officer Commanding
SAMHS Nursing College
Private Bag X1022
Thaba Tshwane
0143

REQUESTING PERMISSION TO CONDUCT RESEARCH STUDY IN THE MILITARY HEALTH SERVICES AT SAMHS NURSING COLLEGE MAIN CAMPUS: 94706819PE MAJ A. COETZEE

1 I would like to request permission to conduct a research study at SAMHS Nursing College Main Campus. The research study forms part of the Master Dissertation I am presently enrolled for at the University of the Free State. Approval from the Expert, Evaluation and Ethical committee of the Faculty of Health Sciences will be obtained before commencement of the research study.

2. I am currently employed by the South African Military Health Services as a facilitator at the Nursing College in Bloemfontein.

3. The aim of the proposed study is to describe clinical supervision of nursing students and pupil enrolled nurses in the South African Military Health Service

CONFIDENTIAL

02-JUN-2011 07:58 From:NUR COLG

4 Thank you for your highly appreciated assistance in this regard!

A Coetzee (mag)
(A. COETZEE)
FACILITATOR SAMHS NURSING COLLEGE BLOEMFONTEIN: MAJ

Remarks:
"The study will be of benefit to nursing education and therefore excellent patient care

(P.M. MOTSEKI)
OFFICER IN CHARGE SAMHS NURSING COLLEGE BLOEMFONTEIN: LT COL

02-JUN-2011 07:58 From:NUR COLG

Remarks:
Approved. The study will benefit the Nursing College board the SAMHS at large

(J.F.M. MABONA)
OFFICER COMMANDING SAMHS NURSING COLLEGE: COL

Remarks:
THE COC MHTF SUPPORTS THE PURPOSE OF THE STUDY AS WELL AS ITS CONTRIBUTION (EXPECTED) TO THE MANAGEMENT OF THE SAMHS NURSING COLLEGE, HOWEVER, THE RESEARCHER MUST GET CLEARANCE FROM THE SAMHS ETHICS COMMITTEE AND POSSIBLY C&I. THE ENTIRE STUDY PROTOCOL MUST BE SENT, EXPLAINING HOW THE CONCENT OF THE STUDY SUBJECTS WILL BE OBTAINED AND WHERE THE RESEARCH RESULTS WILL BE PUBLISHED.

30/05/2011
(L.L. MSIMANG)
GENERAL OFFICER COMMANDING MILITARY HEALTH TRAINING FORMATION: BRIG GEN

02-JUN-2011 07:58 From:NUR COLG

3MH/C/94706819PE

Telephone: 051 4021850
Facsimile: 051 4021877
Enquiries: Maj A. Coetzee

SAMHS Nursing College
Bloemfontein
Private Bag X40003
Brandhof
9324

17 January 2011

The Officer Commanding
1 Military Hospital
Private Bag X1026
Thaba Tshwane
0143

REQUESTING PERMISSION TO CONDUCT RESEARCH STUDY IN THE MILITARY HEALTH SERVICES AT 1 MILITARY HOSPITAL: 94706819PE MAJ A. COETZEE

1. I would like to request permission to conduct a research study at 1 Military Hospital. The research study forms part of the Masters Dissertation I am presently enrolled for at the University of the Free State. Approval from the Expert, Evaluation and Ethical committee of the Faculty of Health Sciences will be obtained before commencement of the research study.

2. I am currently employed by the South African Military Health Services as a facilitator at the Nursing College in Bloemfontein.

3. The aim of the proposed study is to describe clinical supervision of nursing students and pupil enrolled nurses in the South African Military Health Services.

18/04/2011 10:17 0123140338 1MIL HR DEP PAGE 03/06

4. Thank you for your highly appreciated assistance in this regard!

(A. COETZEE)
FACILITATOR SAMHS NURSING COLLEGE BLOEMFONTEIN: MAJ

Remarks:
The study will have a benefit to nursing education and therefore excellent patient care

(P.M. MOTSEKI)
OFFICER IN CHARGE SAMHS NURSING COLLEGE BLOEMFONTEIN: LT COL

18/04/2011 10:17 0123140338 IMIL HR DEP PAGE 04/06

Remarks:

Approved Provided all research guidelines the Military for a Military Personnel are followed.

(Z.W.S. DABULA)
OFFICER COMMANDING 1 MILITARY HOSPITAL: BRIG GENL

DISTR

For Action

SO1 Nursing 1 Military Hospital (Attention: Col Z.Z. Maso)

18/04/2011 10:17 01231403338 IMIL HR DEP PAGE 06/06

CONFIDENTIAL

3MH/C/94706819

Telephone: 051 4021850
Facsimile: 051 4021877
Enquiries: Maj A. Coetzee

SAMHS Nursing College
Bloemfontein
Private Bag X40003
Brandhof
9324

19 January 2011

The Officer Commanding
2 Military Hospital
Private Bag X4
Wynberg
7800

REQUESTING PERMISSION TO CONDUCT RESEARCH STUDY IN THE MILITARY HEALTH SERVICES AT 2 MILITARY HOSPITAL: 94706819PE MAJ A. COETZEE

1. I would like to request permission to conduct a research study at 2 Military Hospital. The research study forms part of the Masters Dissertation I am presently enrolled for at the University of the Free State. Approval from the Expert, Evaluation and Ethical committee of the Faculty of Health Sciences will be obtained before commencement of the research study.

2. I am currently employed by the South African Military Health Services as a facilitator at the Nursing College in Bloemfontein.

CONFIDENTIAL

3. The aim of the proposed study is to describe clinical supervision of nursing students and pupil enrolled nurses in the South African Military Health Services.

4. Thank you for your highly appreciated assistance in this regard!

(A. COETZEE)

FACILITATOR SAMHS NURSING COLLEGE BLOEMFONTEIN: MAJ

Remarks:

The study will be of benefit for the nursing education and therefore excellent patient care.

(P.M. MOTSEKI)

OFFICER IN CHARGE SAMHS NURSING COLLEGE BLOEMFONTEIN: LT COL

Remarks:

Permission granted

19/01/11

(N.P. MAPHAHA)
OFFICER COMMANDING 2 MILITARY HOSPITAL: COL

DISTR

For Action:

SO1 Nursing 2 Military Hospital (Attention: Lt Col R. Hill)

T00/T00 001/001 20/01 2011 12:18 FAX

CONFIDENTIAL

3MH/C/94706819PE

Telephone: 051 4021850
Facsimile: 051 4021877
Enquiries: Maj A. Coetzee

SAMHS Nursing College
Bloemfontein
Private Bag X40003
Brandhof
9324

19 January 2011

The Officer in Charge
SAMHS Nursing College
2 Military Hospital
Private Bag X4
Wynberg
7800

REQUESTING PERMISSION TO CONDUCT RESEARCH STUDY IN THE MILITARY HEALTH SERVICES AT SAMHS NURSING COLLEGE SATELLITE CAMPUS 2 MILITARY HOSPITAL: 94706819PE MAJ A. COETZEE

1. I would like to request permission to conduct a research study at SAMHS Nursing College Satellite Campus 2 Military Hospital. The research study forms part of the Masters Dissertation I am presently enrolled for at the University of the Free State. Approval from the Expert, Evaluation and Ethical committee of the Faculty of Health Sciences will be obtained before commencement of the research study.

2. I am currently employed by the South African Military Health Services as a facilitator at the Nursing College in Bloemfontein.

CONFIDENTIAL

3. The aim of the proposed study is to describe clinical supervision of nursing students and pupil enrolled nurses in the South African Military Health Services.

4. Thank you for your highly appreciated assistance in this regard!

A COETZEE (MAJ)
(A. COETZEE)
FACILITATOR SAMHS NURSING COLLEGE BLOEMFONTEIN: MAJ

Remarks:
The study will be of benefit to the nursing education and therefore excellent patient care

Lt Co
(P.M. MOTSEKI)
OFFICER IN CHARGE SAMHS NURSING COLLEGE BLOEMFONTEIN: LT COL

Remarks:

Recommended with higher authorities in place.

(D.A. McBAIN)
OFFICER IN CHARGE SAMHS NURSING COLLEGE SATELLITE CAMPUS
2 MILITARY HOSPITAL: LT COL

001/001 20/01 2011 08:52 FAX

CONFIDENTIAL

3MH/C/94706819PE

Telephone: 051 4021850
Facsimile: 051 4021877
Enquiries: Maj A. Coetzee

SAMHS Nursing College
Bloemfontein
Private Bag X40003
Brandhof
9324

19 January 2011

The Officer Commanding
3 Military Hospital
Private Bag X40003
Brandhof
9324

REQUESTING PERMISSION TO CONDUCT RESEARCH STUDY IN THE MILITARY HEALTH SERVICES AT 3 MILITARY HOSPITAL: 94706819PE MAJ A. COETZEE

1. I would like to request permission to conduct a research study at 3 Military Hospital. The research study forms part of the Masters Dissertation I am presently enrolled for at the University of the Free State. Approval from the Expert, Evaluation and Ethical committee of the Faculty of Health Sciences will be obtained before commencement of the research study.

2. I am currently employed by the South African Military Health Services as a facilitator at the Nursing College in Bloemfontein.

3. The aim of the proposed study is to describe clinical supervision of nursing students and pupil enrolled nurses in the South African Military Health Services.

CONFIDENTIAL

4. Thank you for your highly appreciated assistance in this regard!

A Coetzee (MAJ)
(A. COETZEE)
FACILITATOR SAMHS NURSING COLLEGE BLOEMFONTEIN: MAJ

Remarks:
The study will be of benefit for the improvement of nursing education and therefore excellent patient care.

Lt Col
(P.M. MOTSEKI)
OFFICER IN CHARGE SAMHS NURSING COLLEGE BLOEMFONTEIN: LT COL

Remarks:

Recommended – for attention of the SANMS Ethical environment to proceed. Mil Sec / Int. Clearance has to be obtained as well.

(J.E. MATTHEE)
OFFICER COMMANDING 3 MILITARY HOSPITAL: COL

DISTR

For Action

SO1 Nursing 3 Military Hospital (Attention: Lt Col I.M.A. Mabaso)

ANNEXURE E

APPROVAL FROM ETHICS COMMITTEES

UNIVERSITEIT VAN DIE VRYSTAAT
UNIVERSITY OF THE FREE STATE
YUNIVESITHI YA FREISTATA

Direkteur: Fakulteitsadministrasie / Director: Faculty Administration
Fakulteit Gesondheidswetenskappe / Faculty of Health Sciences

Research Division
Internal Post Box G40
☎(051) 4052812
Fax (051) 4444359

E-mail address: StraussHS@ufs.ac.za

Ms H Strauss

2011-06-10

MS A COETZEE
P O BOX 31392
FICHARDTPARK
BLOEMFONTEIN
9317

REC Reference nr: 230408-011
IRB nr 00006352

Dear Ms Coetzee

ECUFS NR 64/2011
MS A COETZEE **SCHOOL OF NURSING**
PROJECT TITLE: A DESCRIPTION OF THE VIEWS OF DIFFERENT CATEGORIES OF NURSES ON CLINICAL SUPERVISION IN THE SOUTH AFRICAN MILITARY HEALTH SERVICE (SAMHS).

- You are hereby kindly informed that the Ethics Committee approved the above study at the meeting held on 07 June 2011 on condition that the questionnaire and Information Leaflet have to be available in the language the trial person prefers copies of which have to be submitted to the Ethics Committee.
- Committee guidance documents: Declaration of Helsinki, ICH, GCP and MRC Guidelines on Bio Medical Research. Clinical Trial Guidelines 2000 Department of Health RSA; Ethics in Health Research: Principles Structure and Processes Department of Health RSA 2004; Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa, Second Edition (2006); the Constitution of the Ethics Committee of the Faculty of Health Sciences and the Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines.
- Any amendment, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.
- The Committee must be informed of any serious adverse event and/or termination of the study.
- A progress report should be submitted within one year of approval of long term studies and a final report at completion of both short term and long term studies.
- Kindly refer to the ECUFS reference number in correspondence to the Ethics Committee secretariat.

Yours faithfully

.....
ACTING CHAIR: ETHICS COMMITTEE
Cc Prof A Joubert

339, Bloemfontein 9300,RSA ☎ (051) 405 2812 StraussHS@ufs.ac.za
Republiek van Suid-Afrika / Republic of South Africa

RESTRICTED

1MH/302/6

Tel: 012 314 0487
Facsimile: 012 314 0013
Enquiries: Prof / Lt Col
M.K. Baker

1 Military Hospital
Private Bag X1026
Thaba Tshwane
0143

06 June 2011

CLINICAL TRIAL APPROVAL: "AN EVALUATION OF CLINICAL SUPERVISION OF NURSING STUDENTS AND PUPIL ENROLLED NURSES IN THE SOUTH AFRICAN MILITARY HEALTH SERVICES (SAMHS)"

1. The 1 Military Hospital Research Ethics Committee (1MHREC), adhering to GCP/ICH and SA Clinical Trial guidelines, evaluated the above-mentioned protocol and additional documents.

2. The following members reviewed the study:

   a. Lt Col M.K. Baker: Neurologist, male, chairman 1 MHREC.
   b. Lt Col C.S.J. Duvenage: Specialist physician, female, member 1 MHREC.
   c. Lt Col L.M. Hofmeyr: Otorhinolaringologist, male, member 1 MHREC.
   d. Lt Col D. Mahapa: Dermatologist, female, member 1 MHREC.
   e. Lt Col A.D. Moselane: Urologist, male, member 1 MHREC.
   f. Maj O. Khobo Mpe: Medical Doctor, female, member 1 MHREC.
   g. DR T.J. Marè: Advocate, independent of the organization, male, member 1 MHREC.
   h. Mrs. C. Jackson: Layperson, independent of the organization, female, member 1 MHREC.

3. The following documents were evaluated:

   a. Study protocol: "An evaluation of clinical supervision of nursing students and pupil enrolled nurses in the South African Military Health Services (SAMHS)"

4. The recommendations are: The study was approved on 06 June 2011. The principal investigator Maj A Coetzee will be supervised by Prof A Joubert. Report backs are to be made to the 1MHREC six monthly, in the event of any serious adverse events and on completion or termination of the study.

(M.K BAKER)
CHAIRMAN 1 MILITARY HOSPITAL RESEARCH ETHICS COMMITTEE:
LT COL / PROF

DIST

For Action

Maj A. Coetzee

World Class Clinical Care
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