

(i)

THE NURSE EDUCATORS' PERCEPTION
OF THEIR CLINICAL INSTRUCTION ROLE

BY

SIZENI ANGEL MCHUNU

Submitted in fulfilment of the requirements for the
Degree of M. Cur, Nursing Science Department
University of Zululand

SUPERVISOR : Professor T.G. Mashaba

JOINT SUPERVISOR : Mrs C.S. Mhlongo

SUBMITTED : February 1997

(ii)

DECLARATION

I, Sizeni Angel Mchunu, declare that "The Nurse Educator's perception of their clinical instruction role" is my own work. All sources used or quoted have been indicated or acknowledged by means of complete references.



S.A. MCHUNU

97/6037. 148631

UNIVERSITEIT VAN ZOELOELAND	
UNIVERSITY OF ZULULAND	
BIBLIOTEK / LIBRARY	
KLAS Nr.	
CLASS No.	Z 610 MCH
AANWINS Nr.	09704711
ACCESSION No.	

DEDICATION

This work is dedicated to:-

1. My beloved mother Mrs Balungile Eugenia Mchunu who nurtured in me the virtue of endurance, the love and desire to learn, sacrificed all she had in order to lay in me the foundation of what I am today.
2. My beloved sons, Sfundu and Njabulo whom I possibly deprived of love and care during this study.
3. My two brothers Manciki ("Baby-Baby") and Phumlani. My only sister Bheji.
4. All those who love me and wish me well.

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to all the people who directly and indirectly made the completion of this study possible.

I am indebted to the following:-

- My Supervisor, Professor T.G. Mashaba and my Joint Supervisor, Mrs C.S. Mhlongo for their guidance, support and academic help they gave me during this study.
- Nurse educators who co-operated and assisted me in the completion of this study.
- Mrs N.S. Dlamini for typing my document.
- My dear friends and colleagues for their unfailing support and encouragement.
- The authors whose work I consulted.

ABSTRACT

This cross-sectional descriptive survey attempted to:-

- determine the nurse educators' perception of their clinical instruction role;
- determine the extent to which nurse educators participate in clinical instruction activities;
- establish the extent to which nurse educators actually practise activities that they perceive as their ideal functions
- identify reasons for insufficient or lack of participation of nurse educators in clinical instruction
- identify problems encountered by nurse educators in clinical instruction

This study was conducted in Regions F and H of KwaZulu-Natal Province in South Africa. A questionnaire was used to elicit information from nurse educators that were directly involved in the education and training programme of student nurses undergoing a *basic nursing course*.

The findings indicated that nurse educators perceive assessment, designing of instructional plans, implementation, evaluation and record-keeping in clinical instruction as their ideal functions. The findings also revealed that nurse educators do not sufficiently participate in the execution of the activities that they perceive as their ideal function. Factors such as role overload, lack of clinical credibility and poor preparation during role-taking deterred nurse educators from adequately practising their role functions. Problems such as student absenteeism, lack of facilities, an unmanageable academic workload and distance between campus and practice were also identified as major problems that were experienced by nurse educators.

On the basis of these findings, it is recommended that a structured component of clinical instruction be incorporated into a student tutor's programme, and that clinical laboratories, where they were reported to be non-existent, be provided to bridge the gap between the academic milieu and the students' practice area.

OPSOMMING

Met hierdie dwarsnit-beskrywende ondersoek is gepoog om:

- die verpleegsteropleiers se persepsie van hulle kliniese instruksierol te bepaal;
- vas te stel tot watter mate verpleegsteropleiers deelneem aan kliniese instruksie;
- vas te stel in welke mate verpleegsteropleiers werklik uitvoering gee aan aktiwiteite wat hulle as hulle ideale rol beskou;
- die redes te identifiseer vir onvoldoende- of geen deelname in kliniese instruksie deur verpleegsteropleiers;
- om verpleegsteropleiers se probleme rakende kliniese instruksie te identifiseer.

Die studie is gedoen in Streke F en H van KwaZulu-Natal, Suid-Afrika. 'n Vraelys is gebruik om inligting te bekom van verpleegsteropleiers wat direk gemoeid is met die onderwys en opleidingsprogram van leerlingverpleegsters wat 'n basiese verplegingskursus volg.

Volgens die bevindings, beskou verpleegsteropleiers die waardering, die ontwerp van onderrigplanne, die implementering daarvan, evaluering en die hou van rekords in kliniese instruksie as hulle ideale rol. Daar is ook bevind dat verpleegsteropleiers nie genoegsaam deelneem aan bogenoemde aktiwiteite nie. Deelname word gehinibeer deur onder andere oorlading, swak voorbereiding en 'n tekort aan kliniese geloofwaardigheid. Verdere probleme soos studenteafwesighede, tekort aan fasiliteite, 'n oorweldigende akademiese werkslading en die lang afstand tussen die kampus en die praktyk is ook as belangrike probleme geïdentifiseer.

Op grond van hierdie bevindings word aanbeveel dat 'n gstruktureerde komponent van kliniese instruksie opgeneem word in studenttutors se studieprogramme en dat kliniese laboratoriums voorsien moet word (in die gevalle waar dit ontbreek) ten einde die gaping tussen die akademie en praktyk te oorbrug.

TABLE OF CONTENTS

CONTENTS	PAGE
Title of the study	(i)
Declaration	(ii)
Dedication	(iii)
Acknowledgements	(iv)
Abstract	(v)
Opsoming	(vi)
Table of contents	(vii)
List of tables	(xiv)
List of figures	(xvi)
List of annexures	(xvii)
CHAPTER 1	
ORIENTATION TO THE STUDY	
1.1 Introduction	1
1.2 Background to the study	1
1.3 Statement of the problem	2
1.4 Objectives of the study	2
1.5 Motivation for the study	3
1.6 Significance of the study	3
1.7 Scope of the study	4
1.8 Student nurse education and training in the area of study	4
1.9 Definition of terms	5
1.9.1 Clinical teaching/instruction	6
1.9.2 Accompaniment	6
1.9.3 Nurse educator	6
1.9.4 Basic nursing course	7
1.9.5 Satellite campus	7
1.9.6 Moonlighting	7
1.10 Organisation of the study	7
1.11 Conclusion	8

CONTENTS	PAGE
2.9.1 Multidimensional role of nurse teachers	26
2.9.2 Lack of formal training for clinical instruction	27
2.9.3 Lack of clinical credibility	28
2.9.4 Negative attitude	28
2.10 Theoretical framework for the study : Role Theory	29
2.10.1 Introduction	29
2.10.2 Basic concept of role theory	29
2.10.2.1 Concept Status	29
2.10.2.2 Concept Role	31
2.10.2.3 Concept Role Performance	32
2.10.2.4 Concept Role-Taking	33
2.10.3 Application of role theory to study	34
2.11 Conclusion	36
CHAPTER 3	
METHODOLOGY	
3.1 Introduction	37
3.2 Research design	37
3.3 Scope and delimitation	38
3.4 Population and sample	40
3.5 Research instrument	41
3.6 Pretesting of the instrument	42
3.7 Validity of the research instrument	43
3.8 Ethical consideration	43
3.8.1 <i>Permission to conduct research</i>	43
3.8.2 Confidentiality and anonymity	44
3.9 Data collection procedure	45
3.10 Coding and plan for analysis	45
3.11 Conclusion	45

CONTENTS	PAGE
CHAPTER 4	
DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSION OF FINDINGS	
4.1 Introduction	46
4.2 SECTION A	46
4.2.1 Biographic data (Items 1.1 - 1.2)	46
4.2.1.1 Item 1.1 Gender	
4.2.1.2 Item 1.2 Age group	
4.2.2 Nursing Educational data (Items 2.1 - 2.3)	47
4.2.2.1 Item 2.1 Basic nursing programme undergone	
4.2.2.2 Programme completed for registration as a nurse tutor	
4.2.2.3 Highest professional qualifications of nurse educator	
4.2.3 Professional Status (Items 3.1 - 3.2)	50
4.2.3.1 Item 3.1 Professional Title	
4.2.3.2 Item 3.2 Courses/Subjects taught by nurse educator	
4.3 SECTION B PARTICIPATION OF NURSE EDUCATORS IN CLINICAL INSTRUCTION	53
4.3.1 Item 4.1 Job description for nurse educators	53
4.3.2 Item 4.2 Participation in clinical instruction	54
4.3.3 Item 4.3 Reasons for participation in clinical instruction	55
4.3.4 Item 4.4 Reasons for NOT participating in clinical instruction	55
4.3.5 Item 4.5 Average duration spent in clinical teaching	56

CONTENTS	PAGE
4.3.6 Item 4.5.1 Measurement of time spent in clinical area in relation to job description	57
4.3.7 Item 4.5.2 Adequacy of time spent in clinical area and motivation	58
4.3.8 Item 4.6 Activities that nurse educators mostly engage in during clinical visits	59
4.3.9 Item 4.7 Clinical instruction as an integral part of nurse education	61
4.3.10 Item 4.8 Whose function is clinical instruction?	61
4.3.11 Item 4.9 Ideal duration for clinical visits by nurse educators	62
4.3.12 Item 4.10 Extent to which nurse educators perceive clinical instruction and extent to which they practice it	63
4.3.13 Item 4.10.1 Ideal and actual extent of participation in assessment for clinical instruction by nurse educators	64
4.3.14 Item 4.10.2 Ideal and actual extent of participation in planning for clinical instruction by nurse educators	70
4.3.15 Item 4.10.3 Ideal and actual extent of participation in implementation of clinical instruction by nurse educators	75
4.3.16 Item 4.10.4 Ideal and actual extent of participation in evaluation of clinical instruction by nurse educators	80
4.3.17 Item 4.10.5 Ideal and actual extent of participation in record-keeping related to clinical instruction by nurse educators	85

CONTENTS		PAGE
4.3.18	Item 4.11 Existence/non-existence of problems encountered by nurse educators with clinical instruction	88
4.3.19	Item 4.12 Nature of problems encountered by nurse educators in clinical teaching	89
4.4	Conclusion	91
CHAPTER 5		
SUMMARY OF THE STUDY, REPORT ON FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS		
5.1	Introduction	92
5.2	Summary of the study	92
5.2.1	<i>Statement of the problem</i>	92
5.2.2	<i>Objectives of the study</i>	92
5.2.3	Reviewed literature	93
5.2.4	Methodology	94
5.2.4.1	Research design	94
5.2.4.2	Research instrument	94
5.2.4.3	Population and sample	95
5.2.4.4	Process of data analysis	95
5.3	Research findings	96
5.3.1	Biographic and educational data	96
5.3.2	Job description of nurse educators	96
5.3.3	Average time spent for clinical teaching	97
5.3.4	Nurse educators' activities in clinical area	97
5.3.5	Reasons for non-involvement in clinical teaching	97
5.3.6	The nurse educators' role in the clinical instructional development process	97
5.4	Conclusions	98
5.5	Limitations	99

CONTENT	PAGE
5.6 Implications of the study	100
5.7 Recommendations and suggestion for further research	101
5.8 Conclusion	102
References	103

LIST OF TABLES

TABLE NO.		PAGE
Table 3.1	Number of available and researched nurse educators in institutions under study	41
Table 3.2	Responses to distributed questionnaires	45
Table 4.1	Gender of participants	46
Table 4.2	Age distribution of nurse educators	47
Table 4.3	Basic Nursing programme completed	48
Table 4.4	Programme completed for registration as a nurse tutor	49
Table 4.5	Highest professional qualifications of respondents	50
Table 4.6	Professional titles of nurse educators	51
Table 4.7	Course/Subjects taught by nurse educators	52
Table 4.8	Responses to reasons for participation in clinical instruction	55
Table 4.9	Responses to non-participation in clinical instruction	56
Table 4.10	Responses to time spent in clinical teaching	57

LIST OF FIGURES

FIGURE NO.		PAGE
Figure 3.1	Map of KwaZulu-Natal Province	39
Figure 4.1	Participation and non-participation of nurse educators in clinical instruction	54
Figure 4.2	Measurement of time spent in clinical instruction in relation to job description	58
Figure 4.3	Activities that nurse educators engage in during clinical visits	60
Figure 4.4	Responses to ideal and actual extent of participation in assessment activities for clinical instruction	66
Figure 4.5	Responses to ideal and actual extent of participation in planning activities for clinical instruction	72
Figure 4.6	Responses to ideal and actual extent of participation in implementation for clinical instruction	77
Figure 4.7	Responses to ideal and actual extent of participation in evaluation for clinical instruction	82
Figure 4.8	Responses to ideal and actual extent of participation in record-keeping for clinical instruction	87

LIST OF ANNEXURES

ANNEXURE NO.	PAGE
Annexure A Research Questionnaire	
Annexure B The KwaZulu Department of Health Policy for clinical instruction : Tutors	
Annexure C Permission to conduct research in Natal Nursing College	
Annexure D-H <i>Permission to conduct research in other institutions</i>	

CHAPTER 1

1. ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Nursing as an art and science is directed at providing service that is based on scientific principles (Mellish & Brink, 1992:4). It therefore demands that nurse educators do not transmit theoretical knowledge only but also participate in accompanying the neophytes towards acquisition and development of their clinical skills.

This can, to a certain extent, be done in a classroom through games, role play and simulation exercises, but the classroom scenario excludes the real patient from whom the experiential facet of nursing practice is obtained.

Mashaba & Brink (1994:46) maintain that the nurse educator has to be at the bedside so as to support the learner. This accompaniment will augment development of desired clinical competence in the student. This view is shared by de Tornyay & Thompson (1987:150) who assert that the presence of nurse educators in clinical settings ensures that the theory taught in the classroom is thoroughly integrated with practice in the clinical field. The integration occurs during the student-teacher encounter in a clinical experiential context. This is where the nurse educator facilitates the clinical learning experience of the students. During such encounters, guidance and support are required to ensure continuity of learning while the student is exposed to challenging concrete situations and real clinical problems. This will allow translation of theoretical knowledge into service in the clinical field (Hinchliff 1986:61; Koen 1991:30).

1.2 BACKGROUND TO THE STUDY

Clinical instruction is one of the functions of nurse educators. It provides them with an opportunity to expose student nurses to realities of the clinical field that students cannot capture in classroom situations. The clinical field is an important

environment for learning practical skills for this is where a nurse educator supports the student when she is most vulnerable. It appears however that these views are at variance with the perceptions of nurse educators. In reality clinical teaching receives very little attention from nurse educators (Uys 1992:237). This view is shared by Alberts (1991:37) who states that there is an acceptance of involvement in both theoretical and clinical teaching, but nurse educators are less involved in clinical than they are in theory teaching.

The nurse educators' reluctance to engage in clinical teaching has been attributed to many reasons. The observation made by Alberts (1991:37) that nurse educators are working under non-ideal conditions, could be one of them. It has also been postulated that new role expectations have placed excessive demands on nurse educators. Such expectations emanate from progressive changes in nursing, like nursing colleges becoming university affiliates (Goodchild-Brown 1989:54). Despite an increased load, nurse educators still have to nurture students and help them to become proficient practitioners.

This study then aimed at exploring and describing perceptions of nurse educators of their role in clinical teaching. It also aimed at establishing the extent to which they practise what they perceive as their duties.

1.3 STATEMENT OF THE PROBLEM

There is an apparent lack of sufficient participation of nurse educators in clinical instruction of student nurses. As a result the students' clinical learning is invariably compromised.

The study then seeks to establish if this assumption can be affirmed by addressing the question : What do nurse educators perceive as their role in clinical instruction?

1.4 OBJECTIVES OF THE STUDY

The objectives of the study were:-

- * To determine the nurse educators' perception of their role in clinical instruction.
- * To determine the nature and frequency of student accompaniment i.e. extent to which nurse educators participate in clinical teaching.
- * To establish the extent to which nurse educators actually practise the activities that they perceive as their ideal function.
- * To identify reasons or causes of insufficient or non-involvement of nurse educators in clinical instruction.
- * To identify problems experienced by nurse educators with clinical instruction.

1.5 MOTIVATION FOR THE STUDY

Motivation for conducting this study emanated from the researcher's long-standing concern about the nature and frequency of clinical instruction by nurse educators. The concern dated back to the researcher's student days when an observation was made that nurse educators were distancing themselves from clinical teaching. Their visits to the clinical area were short, apparently unplanned and not beneficial to the student for whom they were meant.

This concern grew when the researcher was working with nurse educators later in her career and still observed the reluctance with which clinical teaching was done. The unwillingness and apparent lack of commitment to clinical instruction seems to continue.

Studies have been done to determine effective and ineffective clinical instruction behaviours and involvement of nurse educators in the exercise. These studies reveal that clinical teaching has not received the attention it deserves (Uys 1992:22). Myrick (1991:45) states that even new nurse graduates from the baccalaureate nursing programs continue to verbalise feelings of inadequacy in the clinical setting.

1.6 SIGNIFICANCE OF THE STUDY

The findings of this study should help with the following:-

- 1.6.1 Clarification of opinions of nurse educators about their clinical instruction role with a view to improving the quality of student accompaniment and consequently their competence in nursing skills.
- 1.6.2 Initiation and/or improvement of staff development programmes in institutions where ineffective clinical teaching will be manifest.
- 1.6.3 Development of a clinical instruction model suitable for the area in which the study was conducted, therefore benefitting the institution.
- 1.6.4 A number of studies have been done in areas of clinical instruction. One such study was conducted by Mhlongo (1994) which focussed on the role of a unit sister in teaching student nurses. Another study by Brink (1984) was conducted to identify and describe the tutors' perception of their role function and status. An apparent lack of studies focussing on how nurse educators perceive their role in the clinical field is evident. The results of this study will, therefore, fill the gap in relation to clinical teaching studies that have been done, and will add to the pool of knowledge in nursing as a growing clinical science.

1.7 SCOPE OF THE STUDY

The study focused on nurse educators that were directly engaged in education and training of nurses that were undergoing a basic nursing course.

Geographically, the study was confined to institutions within Regions F and H of the KwaZulu-Natal province (see Figure 3.1). Only those institutions offering the basic nursing course were selected.

1.8 STUDENT NURSE EDUCATION AND TRAINING IN THE AREA UNDER STUDY

In 1985, the South African Nursing Council promulgated Regulation 425 of February 1995. This regulation provided for the establishment of nursing colleges. This meant that hospital-based nursing schools that had previously

been under the administration of the matron could apply for college status. The implication was that these would become autonomous institutions of tertiary learning under the administration of campus principals.

In Region F, the Natal Nursing College was established. This college comprised three (3) campuses that is Addington, King Edward and R.K. Khan. Grey's and Northdale campuses fell outside the area of study. The Natal Nursing College affiliated with the University of Natal Nursing Science Department. Nurse training is also offered at private institutions that applied and obtained college status. These are St Augustine's and St Aiden's Colleges' in Durban. Prince Mshiyeni in Umlazi was made a satellite campus of Edendale in Pietermaritzburg.

In Region H, Ngwelezana Nursing College acquired college status in 1986. It functions administratively as the Main Campus for Benedictine (Nongoma) and Charles Johnson Memorial (Nqutu) nursing colleges. These satellite campuses were excluded from the study since they fell outside the demarcated project area. The Ngwelezana Nursing College is affiliated to the University of Zululand Nursing Science Department.

Two universities (University of Natal and University of Zululand) in the area under study offer the B Cur programme and therefore train and educate student nurses undergoing the basic comprehensive nursing course. All the above-mentioned institutions function in accordance with the regulations of the South African Nursing Council which sets minimum requirements for training.

1.9 DEFINITION OF TERMS

The definition of terms given hereunder is meant to give clarity to the content of the study and to ensure that the reader has the same understanding of the concepts as the researcher.

1.9.1 CLINICAL TEACHING/INSTRUCTION

van Hoozer, Pratton, Ostmoe, Weinhotz, Craft, Gjerde & Albanese (1987:175)

define clinical teaching as acting and interacting with students, clients and health professionals in settings where people are in need of health care, to promote both maximum learning of students and maximum health for clients. This means that nurse educators have a dual responsibility to nursing students and to patients/clients.

In this study, clinical teaching refers to teaching of students in the clinical area i.e. where patients and clients are. This area is away from the classroom so that students are also taught psychomotor and interactive skills in the real life world of the sick person.

1.9.1 SATELLITE CAMPUS

1.9.2 ACCOMPANIMENT

Generically to accompany means to escort, attend to, support and co-exist with (Concise Oxford Dictionary 1989:6).

1.9.3 NURSE EDUCATOR

The South African Nursing Council defines accompaniment as the conscious and purposeful guidance and support for student based upon her unique needs, by creating learning opportunities that make it possible for her to grow from passiveness to involvement, to independent, critical practice. This accompaniment takes place in conjunction with direct involvement and physical presence of the tutor, supplemented by availability of guidelines and learning aids (Mellish & Brink 1990:223).

CHAPTER 1. DEFINITION OF TERMS

In this study, accompaniment will refer to direction, support, assessment, supervision, assistance and evaluation of the students' activity by a nurse educator in the clinical setting.

1.9.3 NURSE EDUCATOR

Doheny, Cook & Stopper (1988:26) define nurse educator as a nurse who teaches nursing in a formalised education setting. Generally it means a registered nurse who has an additional qualification of nurse tutor registered by the South African Nursing Council. For the purpose of this study, nurse educator

will refer to a hospital nurse tutor, nursing college tutor and university nurse lecturer.

1.9.4 BASIC NURSING COURSE

This will refer to a rigorous programme of education and training of a matriculated person to prepare him/her to be registered as a nurse (general, psychiatric, community) and midwife in accordance with the provisions of the South African Nursing Council R425 of February 1985 as amended. This will therefore, exclude pupil auxiliaries, pupil nurses and students undergoing a bridging course.

1.9.5 SATELLITE CAMPUS

This is a branch of the main campus which although physically removed from it, is for all purposes regarded as part of the main campus.

1.9.6 MOONLIGHTING

Broussard, Deloussaye & Poirrier (1996:82) define moonlighting as work performed in faculty members' own time with direct remuneration. In this study, "Moonlighting" will mean time taken by a nurse educator to work in a patient care situation with intent to get extra income and to update clinical skills in order to remain clinically viable.

1.10 ORGANISATION OF THE STUDY

CHAPTER 1 : Presents an outline of the study.

CHAPTER 2 : Will discuss reviewed literature and studies related to the role (ideal and actual) of the nurse educator. It also discusses the theoretical framework of the study.

CHAPTER 3 : Will present a discussion of the research methodology.

CHAPTER 4 : Will present analysis and interpretation of data collected from nurse educators.

CHAPTER 5 : Will present report on findings, conclusion, limitations and recommendations.

2. LITERATURE REVIEW

1.11 CONCLUSION

In this chapter, introduction to the study has been made. It presents introduction; background to the study; problem statement; objectives of the study; motivation for the study; significance of the study; scope and limitations of the study; student nurse training and education in regions under study; definition of key concepts and organisation of the study.

The clinical setting that also was the location of the study was a hospital containing 100 beds. This was the reason for choosing this hospital as the study site in order to assist them to overcome some of the challenges facing them. Literature studied on this subject focused on the clinical setting, the role of the educator and related aspects, possible factors responsible for poor learning in this function and possible approaches by nurse teachers in the clinical area. It appeared that several studies have been conducted on the role of the practitioner-teacher in nursing (Rosen & Jones (1994, 1998), evaluation in clinical teaching (Maidor 1991, 97) and students' perception of their own experiences in the clinical area (Winder 1997, 1998). However, there is still a dearth of studies on what nurse educators perceive as their own role in clinical teaching.

2.2 EXPLORATION OF THE MEANING OF THE CONCEPT 'CLINICAL INSTRUCTION'

Clinical instruction is a practice-oriented teaching given in a clinical or simulated laboratory situation (S.A.N.C. Terminology List 1994). Clinical instruction occurs in the presence of a teacher and a student, individually and jointly. According to Vignocchi (1998) clinical instruction may be seen as an extension of formal teaching that takes place in the classroom. It consists of either a planned, goal-oriented activities that are aimed to teach students and/or

CHAPTER 2

2. LITERATURE REVIEW**2.1 INTRODUCTION**

It is generally accepted in nursing and nursing education that clinical practice for students is an important part of learning. Such experiences should take place in clinical practice situations and must be directed and controlled activities during which students come into contact with health care consumers. Students are exposed to real situations because these contribute to development of skills and attitudes required of a professional nurse.

The clinical setting that is so vital for socialisation and development is foreign and confusing to students. It is for this reason that nurse educators need to be with students in order to assist them to become skilful in this area of learning. Literature surveyed on this subject focused on the clinical instruction role of nurse educators and related aspects; possible factors responsible for poor fulfilment of this function and problems encountered by nurse teachers in the clinical area. It appears that several studies have been conducted on the role of the practitioner-teacher in nursing (Mason & Jinks 1994:1063); evaluation in clinical teaching (Mulder 1991:47) and students' perception of their own experiences in the clinical area (Windsor 1987:150). However, there is still dearth of studies on what nurse educators perceive as their own role in clinical teaching.

2.2 EXPLORATION OF THE MEANING OF THE CONCEPT "CLINICAL INSTRUCTION"

Clinical instruction is practice-oriented teaching given to students in the clinical laboratory situation (S.A.N.C. Terminology List 1994:4). Clinical instruction occurs in the presence of a triad, that is, student, instructor and patient. According to Woodrow (1986:1) clinical instruction must be seen as an extension of formal teaching that takes place in the classroom. It consists of carefully planned, goal-oriented activities that are meant to teach students application of

theory of nursing to actual patient situations.

Cele (1990:5) sees clinical instruction as the teaching of nursing students, which occurs where patients and clients are. Teaching in the practice setting equips students with many skills such as caring, interpersonal and problem-solving skills. Development of such skills requires a nurse educator to actually go along with students to clinical area (Mashaba 1994:45). Clinical instruction is further defined by Gunter (1980:22) as part of teaching that is concerned with imparting information and knowledge. Teaching is accomplished through instruction.

2.2.1 TERMS THAT ARE SYNONYMOUS WITH CLINICAL INSTRUCTION

To throw some light into further understanding of clinical instruction, the reader is given other concepts below, which have the same meaning as clinical instruction.

CLINICAL TEACHING

Teaching is a system of actions that are designed and intended to bring about learning. It is seen as a practical activity that equips learners with knowledge and skills that enable them to make sound judgement about situations (Hlatshaneni & Masinga, undated:22-23; Kruger and Muller 1988:95).

Clinical teaching therefore includes all activities that promote learning of students in the clinical area. Such activities may be cognitively-, affectively- or psychomotor-oriented. In this manner students learn to make decisions pertaining to patient care as they mature to become professionals.

Clinical instruction and clinical teaching appear to semantically connote two different things. However, one (instruction) is embraced in the other (teaching). In this study therefore these concepts will be used interchangeably to mean the same thing. They are to be seen as processes whereby a qualified nurse teacher uses knowledge and expertise to impart skills, values, beliefs and knowledge to a student nurse. This is done by means of suitable methods such as

demonstrations, lecture demonstrations, case studies and clinical nursing conferences. These make learning in the clinical area to be meaningful. Guidance, support and supervision are essentials in effecting clinical teaching.

CLINICAL PRACTICE

Clinical practice may be confused with clinical instruction. In this study it will be used to refer to actual engagement of nurse tutors in hands-on-care of patients in order to effectively help students to learn through imitation.

2.3 PURPOSE AND VALUE OF CLINICAL INSTRUCTION

The primary purpose of clinical instruction especially by a nurse educator is to provide students with opportunities to apply the theory they have learnt in class. This ensures that students come into contact with actual patients (de Tornyay & Thompson 1987:145). Clinical instruction prepares neophytes to be competent professional nurses who, in turn, will teach peers and later other neophytes.

Mellish & Brink (1987:218) believe that clinical competence can be achieved by applying theory in clinical settings. This is necessary for maintaining high professional and nursing standards. Clinical instruction by nurse educators also helps to support students when they are most vulnerable and unsure. It serves as a platform to orientate the learner to acceptable standards of nursing practice (Mellish & Brink 1987:22; Reilly & Oermann 1985:37).

2.4 NURSE EDUCATORS' CLINICAL OBLIGATION

Clinical teaching is seen as the core of all nursing education (Carpenito & Duespohl 1985:111). Because it is such a complex art, nurse educators have to be involved in the learners' education throughout their training (Ferguson 1996:836; Hinchliff 1986:61). Harri (1996:1098-1099) is of an opinion that nurse educators are the ones who are required to provide well-planned, up-to-date and cost-effective education. Since nursing is both a science and an art the nurse educator's helping hand should extend to the clinical area, where practical skills are learned by students.

Clinical instruction is not always taken with the seriousness it deserves. This is shown in a study conducted by Clifford (1996:604) on the clinical work of nurse teachers. Results of this study revealed that the clinical role of nurse educators was of low priority. This was seen to be associated with the transfer of nursing education to the higher education sector, requiring nurse educators to adopt a new culture in relation to prioritising their work.

The above results are supported by Mashaba (1994:310,311) in a study in which the status of the students undergoing a basic nursing course was explored. The students expressed feelings of frustration and conflict. The reason advanced was the daily absence of their tutors from the wards and clinics. They also indicated that activities done in the wards and clinics bore little resemblance to what was taught in the lecture room.

The findings of this study indicate the essentiality of the nurse teacher's availability in clinical settings, so that she can integrate the theory taught in class with practice. Nurse educators themselves are becoming aware that they cannot produce scholarly work through theoretical teaching only, but they are also under growing pressure to be engaged in clinical practice teaching (Broussard et al 1996:64). It is perhaps for this reason that Woodrow (1994:613) comments:-

"The lecturer-practitioners who seek to avoid patients should question whether they remain in nursing, and are obviously ill-suited to become role models of advanced nursing practice."

Acknowledgement of the significance of the clinical role of the nurse educator is indicated by several studies that have been undertaken. These studies attempt to identify the nature and extent of nurse educators' involvement in clinical instruction.

Nolan (1987) as cited by Lee (1996:1126) conducted a study on 399 nurse educators to identify the tasks they normally perform during their working time.

The results showed that they mainly engaged in the following tasks:-

- * classroom teaching
- * administration
- * preparation of lessons and marking of tests and examinations
- * student counselling and other unspecified duties

It is noted with concern that clinical teaching does not feature anywhere in the above study results. Lee (1996:1128) observes that very little of the nurse educator's time is spent in clinical activities.

Davis, White, Riley & Twinn (1990:71) conducted a survey on the role of the nurse teacher in the clinical setting. Interviews included both students and nurse teachers. The following functions, among others, were identified:-

Liaison, giving support, monitoring progress and participation in the assessment process. Clinical teaching was mentioned neither by students nor nurse educators. Lack of clinical guidance has adverse implications on student development. Noel, Levitz and Saluri (1987) as cited by Mashaba & Mhlongo (1995:366) maintain that student wastage may be due to, among others, inadequate clinical teaching and guidance by nurse educators.

2.5 CATEGORIES OF NURSING PERSONNEL WHO SHOULD PARTICIPATE IN CLINICAL INSTRUCTION

Although clinical instruction is an integral component of nursing education, confusion still exists about who the participants should be. The role of participants remains ill-defined (Cele 1990:1-6). Mellish & Brink (1987:223-226) state that clinical instruction should not be confined to professional nurses but must include college staff. They believe that a tutor's role extends beyond classroom teaching and demonstration area into the clinical field. It must, therefore, be possible for a tutor for part of the time at least, to be physically present in the clinical area to teach students.

Woodrow (1994:571) is of an opinion that nurse educators have responsibilities both in academic and clinical settings. In addition to classroom teaching, they have to be role models of excellence for students in patient care. They have to be seen as practice-based resources and support system for the teaching role of the clinical instructor. It is perhaps for this reason that Mashaba (1994:46-47) states that the clinical instructor, if there is one, should supplement and complement the nurse educator. The latter cannot, therefore, shirk the responsibility of offering the clinical component of the subject to other people.

Some nurses feel that a nurse educator is a teacher of nursing, and should be seen as an expert in teaching in clinical settings as well as in the classroom. They, therefore, would like to see tutors undertaking more and more of clinical instruction (Cele 1990:21). This is confirmed by the results of a study that she conducted on clinical instruction of student nurses in nurse training schools in the then KwaZulu. Clinical instructors indicated that this is the function of the tutors primarily and then ward sisters, paramedical and medical staff. To further affirm this view Searle (1985) sees clinical instruction as the responsibility of the tutor and to a lesser extent, of the professional nurse in charge of a nursing unit (Mhlongo 1994:33).

Mellish & Brink (1987:218-219) are also of an opinion that clinical instruction is the responsibility of the unit professional nurse because she has developed expertise in the field. She, therefore, cannot sidestep this function. Reilly & Oermann (1985:12) however, contradict this view. They believe that clinical teaching, as an indispensable dimension of nurse education is the function of the nurse educator. It also appears that nurse educators themselves perceive it as their function.

Cele (1990:6) observes that in spite of the heavy teaching load nurse educators do some clinical teaching. They appear to be keen to improve correlation of theory and practice and also to remain credible in the eyes of the students.

The foregoing studies show absence of unanimity as to who is exclusively responsible for clinical instruction. Some authors are of the opinion that nursing, medical and paramedic staff in contact with students have to give clinical guidance.

2.6 SCOPE OF CLINICAL INSTRUCTION

de Tornyay & Thompson (1987:59) believe that students undergoing a basic nursing programme are prepared to enter the profession with many skills. The instructional process should, therefore, address all spheres (domains) of learning. This is affirmed by Cele (1990:29) that the instructional process is to accommodate intellectual, affective and psychomotor dimensions. The S.A.N.C. (R425, February 1985:2) as amended, also requires that cognitive, psychomotor and affective skills required for application of the scientific approach to nursing be taught to students when introducing them to nursing science.

2.6.1 TEACHING PSYCHOMOTOR SKILLS

If students have to learn psychomotor skills effectively, a teacher is needed. van Hoozer et al (1987:47) contend that a teacher is a potent environment for learners and she is the one who structures conditions that will involve the learner in the learning process. She is also to promote learning, which constitutes change of behaviour. The presence of a tutor is essential because performance of nursing skills requires conscious application of scientific facts and principles (Guinee 1978:34). These are taught in class by the teacher and she, together with students, transfers them to patient care in the clinical area.

2.6.2 TEACHING AFFECTIVE SKILLS

Affective competencies, moral reasoning and value-based behaviour, are essential in skilled nursing practice. They are just as important as the psychomotor and cognitive skills. They must, therefore, be taught as rigorously as competencies in these two domains (Reilly & Oermann 1985:11). Their importance is further affirmed by Mashaba (1994:66) when she states that primarily, teachers must deal with the affective domain in guiding students, using

carefully selected methods.

To achieve a goal of being a good nurse, one must develop the technical, cognitive, caring and intuitive skills that are a reality of nursing. This was expressed by male student nurses when a study was undertaken to explore how they perceived their clinical experience (Streubert 1994:28). This is an indication that students need to be taught affective skills. In yet another study by Nelms et al (1993:18) it came out clearly that students believe they do learn about caring from teaching staff, as well as from other health care staff that they encounter. If students are to be prepared to proficiently practise the art of caring, nurse educators have to take a renewed look at how they socialise student nurses. Since caring is the essence of nursing' nurse educators have to aim at producing caring registered nurses that are in turn, capable of giving humane care to patients and clients (Reilly & Oermann 1985:4; Schoenly 1994 : 210).

2.6.3 TEACHING COGNITIVE SKILLS

Solutions to problems in patient care and delivery of such care, are complex and they require a great deal of cognitive skills. According to Mellish & Brink (1987); Quinn (1988) and Reilly & Oermann (1985), the practice area is problem-laden and requires the student to use problem-solving and decision-making skills. Decision-making is a process during which a person is able to choose an option of action from among several alternatives in order to achieve a goal or to solve a problem. This is made possible by the presence of a nurse educator as an accompanier of the students.

Another cognitive skill nurse educators teach in the clinical area is critical thinking. French (1995:72) sees critical thinking as an ability to "generate options, to see possibilities, to discriminate intelligently, to be creative and to identify new ideas". It is a challenge to nurse educators that teaching of nursing skills is not enough. Psychomotor nursing skills that are chosen must be done according to how appropriate they are to an existing problem situation. According to Reilly & Oermann (1985:155) critical thinking represents the thought process

that underlies problem-solving and decision-making. These need to be taught by nurse educators who possess them.

Hartley & Aukamp (1994:35) conducted a study that measured critical thinking skills of nurse educators. The findings from fifty full-time nurse educators involved in both clinical and classroom instruction showed that they possess a higher level of critical thinking skills than student nurses.

It is for this reason that nursing students must be exposed to clinical experiences by their nurse educators. The environment allows for imparting of problem-solving, decision-making, leadership and some clinical judgement skills. Campbell & Kinion (1993:138) are of the opinion that strategic decisions made by nurse leaders are central to high quality health care.

2.6.4 TEACHING CLINICAL RESEARCH SKILLS

Nurse educators also have a role to play in teaching research. According to Cele (1990:6) nurse educators must encourage clinical research and encourage implementation of findings in the clinical area. Clinical research is patient-centred. It will therefore, broaden the nurse's scope in respect to actual clinical problems. Mashaba (1994:58) also believes that students can play a role in this process. They can acquire nursing and clinical research skills. Nurse educators should therefore appreciate how indispensable they are in clinical teaching.

2.7 PHILOSOPHY AND POLICY REGARDING CLINICAL INSTRUCTION AND LEARNING

Competent practice in a nurse is largely influenced by her own philosophy of life. However, one's philosophy about life, nursing and nursing education may differ from what her profession expects. Other influences, therefore, have to be exerted on the person to inculcate acceptable standards of practice. As a result, a nurse's practice is influenced by values of her society, professional and registering bodies, employing institutions and heads of departments of such institutions.

2.8 The South African Nursing Council (SANC) as a statutory body that sets minimum requirements for nurse education has issued guidelines for clinical practice. These are contained in R425 of February (1985:8) as amended. These guidelines are based on the following principles:-

2.8.1 The South African Nursing Council requires that all available resources be identified and that learning opportunities be provided to ensure that a student develops into a competent registered nurse.

Such opportunities will ensure that a student is able to practice and master skills in clinical nursing, nursing interventions, management and teaching. It further requires that this be made possible through accompaniment for the full duration of the programme.

The significance of clinical teaching necessitates that Departments of Health that control nurse training and education within provinces/regions stipulate their own policies in relation to clinical instruction. Some of these policies are specifically meant for nurse educators.

The then KwaZulu Department of Health set out its policy for clinical instruction by tutors (see Annexure A). Briefly the policy states that a tutor is expected to lead in clinical instruction because she is seen as a teacher of all nursing. She is expected to spend at least 8 hours per week in clinical area. She is also expected to engage in a number of activities, such as setting clinical learning objectives, preparing and revising clinical workbooks, monitoring student progress, co-ordinating activities of those engaged in instruction and also arranging for practical examinations.

2.8 THE ROLE OF THE NURSE EDUCATOR IN THE CLINICAL INSTRUCTION PROCESS

A fully fledged and qualified nurse educator assumes his/her role after a period of initiation and socialisation.

2.8.1 SOCIALISATION INTO THE ROLE

Nursing is a subculture that is characterised by its own values, skills, traditions, knowledge and patterns of behaviour. From generation to generation, these values have been transmitted to the neophytes of the profession through a process of socialisation.

2.8.2 THE IDEAL EXPECTED ROLE OF NURSE EDUCATOR IN CLINICAL

Quinn (1988:86) defines socialisation as an induction into the expected behaviours and roles. It is also seen as a process which shapes human behaviour and prepares people to function in the adult society. Socialisation is primary when it occurs during the formative years of a child, when the child is oriented to values of a society in which he lives (Chan 1995:30-34). These values have to be assimilated into the adult world through secondary socialisation. Part of secondary socialisation is occupational when a person is oriented into an occupational role.

Nursing as a sub culture socialises people into the role of a nurse through training (Abraham & Shanley 1992:10; Chan 1995:80). Nurse training is a mechanism of ensuring that values of the nursing profession are inculcated into the professional nurse. This is done by senior members of the profession like nurse educators, clinical instructors and clinical nurse practitioners. Mashaba (1994:314) is of an opinion that nurse educators have to take a lead in this process.

Nurse educators are oriented to their teaching function through the same process. During their training and education they learn how to teach others. They learn through observing, imitating and following instructions in skills acquisition. This introduces them to shared meanings and perceived roles of

nurse educators (Abraham & Shanley 1992:10). This occurs when people identify models and imitate their behaviour (Mashaba 1994:320; Quinn 1988:39).

The nurse educator's role develops over years of training and education. Both these processes ensure that nurse educators function properly within their roles after having been equipped with the necessary knowledge, skills and attitudes that they have to pass on to student nurses later in their career. Student tutors need to be given an opportunity to see how accompaniment works in reality in order to develop skills in this area (Mellish & Brink 1990:223).

2.8.2 THE IDEAL/EXPECTED ROLE OF NURSE EDUCATOR IN CLINICAL INSTRUCTION

To ensure effective clinical teaching and education, it is expected that nurse educators engage in the following activities:-

2.8.2.1 ASSESSMENT

Kenworthy & Nicklin (1989:44) define assessment as measurement that directly relates to the quality and quantity of learning and as such, is concerned with student progress and attainment. This exercise is associated with several tasks, including the following:-

- identifying the need to get clinically involved. This enables nurse educators to determine reasons for her involvement (Mashaba 1994:51).
- assessing the entry behaviours which determine if the learner possesses the necessary prerequisites for accomplishing learning objectives. This assists in identifying previous knowledge, level of motivation, intellectual and emotional maturity
- learning needs are diagnosed and also learning experiences that will meet such needs (Cele 1990:28-29; Mason 1990 in Mhlongo 1994:23; Woodrow 1993).

2.8.2.2 DESIGNING AN INSTRUCTIONAL PLAN

Assessment of learning needs leads to a teaching diagnosis (Cele 1990:29). It is the basis upon which planning for instruction rests. The nurse educator therefore, has to set clinical learning objectives for learners and identify learners' needs. These must be set at the beginning of a clinical experience so that learners know what is expected of them. She also has to participate in planning clinical assignment and communicating with students. The nurse educator is seen as a person who should take a lead in designing assessment tools (van Hoozer et al 1987:75; Woodrow 1994). Designing a plan of clinical teaching is meant to fulfil the aim, which is integration of theory and practice.

2.8.2.3 IMPLEMENTATION

Implementation is a phase of actual delivery of instruction. van Hoozer et al (1987:72) defines instruction as a purposeful and directed activity during which learners interact with a teacher or teacher-prepared material. It implies a transfer of classroom knowledge to patient care. To realise this goal, a nurse educator should participate with students in direct patient care while exhibiting effective teaching behaviour. She is also expected to monitor the clinical experience by being available to students (van Hoozer et al 1987:275; Clifford 1994:14).

In order to instruct effectively, the nurse teacher needs to be clinically competent in order to produce practitioners who will function in the future (Castledine 1994:1000). This is endorsed by Krichbaum (1994:311) and Fawcett & McQuenn (1994:266) who state that a nurse educator who is seen as a role model of excellence must be clinically credible. This means being up-to-date theoretically while maintaining some basic clinical skills. A clinically credible nurse teacher is able to talk and instruct from a position of authority (Orchard 1994:248).

It is also argued that lecturers who lack clinical skills devalue clinical practice. This is so because they have to be both professional teachers and professional practitioners. Qualifications are considered to be of limited relevance if not accompanied by clinical competence and expertise (Woodrow 1994:661).

Clinical teaching should be effected all the time whenever clinical nursing occurs (Mellish & Brink 1990:224). Nurse educators, however, cannot be in clinical areas because of classroom demands. They need to plan their time and go to clinical area with set objectives.

A number of strategies can be used for clinical teaching. These include simulation in laboratories, nursing conferences, demonstrations and lecture demonstrations. As students also learn through imitation, precept and example can be effective (Mellish & Brink 1990:225). Accompaniment of students is another way in which clinical teaching is effected. The stand of the S.A.N.C. in respect of accompaniment is that it is indispensable in all teaching situations. Accompaniment should entail supporting and directing the student's activities. During such accompaniment, the tutor is expected to supervise, guide and assist students.

2.8.2.4 EVALUATION

Evaluation of student nurses is undertaken to determine if students are becoming clinically competent. The principal participants in clinical evaluation are course teachers, clinical supervisors and students themselves (Kenworthy & Nicklin 1989:128-9). Mellish & Brink (1990:229) believe that clinical evaluation is the responsibility of tutors, unit professional nurses in charge; clinical nursing service manager and any other registered nurses. The role of the nurse educator is to examine the outcome of her instruction to establish if acceptable standards have been attained. She has to use appropriate evaluation tools and give

constructive feedback to students on their performance. This allows for replanning if the student's performance indicates a need for re-instruction.

Nurse educators do formative and summative evaluation. Formative evaluation helps the teacher and the learner to establish if there are learning needs and what they are. Polit & Hungler (1987:160) see it as an ongoing process of providing evaluative feedback. It needs to be done throughout the course in order to assist in the development of the student's clinical skills. Summative evaluation is done to determine whether the desired clinical skills have been developed in the student. It is conducted at the end of the course or a particular level.

2.8.3 THE PERCEIVED CLINICAL INSTRUCTION ROLE OF NURSE EDUCATORS

Conceptually, perception refers to meaning attached to the information received through human senses (Woolfolk 1990:232). van Hoozer et al (1987:6) see perception as a form of discriminative behaviour involving the overall activity of a person. They further state that it is influenced by the person's attitudes, emotions, experiences, expectations and environmental variables. Perception allows for choosing of things that have meaning to one's life.

For the purpose of this study, perception will refer to the interpretation by nurse educators of their clinical instruction obligations. It will explain what nurse educators think and accept as their role in clinical instruction. The basis of the perception is probably grounded on the way a nurse educator is socialised during role-taking and the well known three-dimensional function of any registered nurse, that is, professional, administrative and teaching responsibilities. The way nurse educators perceive their role is important because it will determine what activities are done and how they are done.

Lee (1996:1129) conducted a study in which she explored how nurse educators perceive their role in clinical area and how it was perceived by students. Although students perceived nurse educators as clinical specialists, nurse

educators did not perceive themselves as such. They saw themselves as counsellors and student visitors. Actual involvement in student teaching, supervision and evaluation was not mentioned.

In another exploratory study done to investigate the role of the nurse educator, the results indicated that most nurse educators consider clinical teaching as important, but that they should not be expected to do it (Fawcett & McQueen 1994:264-271).

Clifford (1994:272) in her study, explored the role of nurse educators. Results revealed that they were uncertain of the nature of their clinical responsibilities. This may explain why nurse teachers spend minimal amount of time in clinical teaching work (Mashaba 1994:50).

Not all nurse educators, however, affirm this view. A study was conducted by Steele (1991) in Broussard et al (1996:86) on the role and role strain experienced by nurse educators. Their response revealed that they identified themselves as nurses who teach both theory and clinical skills. This shows that nurse educators are aware of their teaching role in clinical area. Mashaba (1994:46-47) confirms this when stating that some nurse educators find it unnecessary to deliberate on this because the clinical application of theory is implicit in the nurse educator's function. She believes that the ultimate responsibility for this function rests with the nurse teacher.

Many tutors are keen to teach in clinical areas and a great deal of clinical teaching has been incorporated into their teaching programme (Hinchliff 1986:267). This still shows that they perceive clinical teaching as their responsibility.

Brink (1984:252-253) conducted a study on the registered nurse tutors in South Africa. Results revealed that nurse educators perceive the following, among others, as their duties in clinical area:-

- selection of instructional strategies directed at average students
- assisting and guiding students to identify their learning problems and needs; and
- supervision of clinical experience

Some, however, indicated that the above activities were not practised. This is an indication that there exists a gap between job description, ideal role and activities that nurse educators actually engage in. She further points out that there is a significant difference between ideal and actually practised roles. This suggests that nurse tutors do not carry out in practice what they profess to believe in.

2.8.4 THE ACTUAL CLINICAL TEACHING ROLE OF NURSE EDUCATORS

Another area of uncertainty in the nurse educator's role relates to actual activities relating to clinical teaching. Actual activities cover what nurse educators do in clinical areas, how often they go there and how long they stay to adequately facilitate clinical learning.

A study conducted by Clifford (1995:14) on the role of teacher-practitioners, revealed that nurse educators visit clinical area about once weekly to once per fortnight or month. It also came to light that time spent ranged from less than one hour to seven hours per visit. This appears to be minimal. It is perhaps why Mason & Jinks (1994:1070) suggest that nurse educators must engage in alternate periods of practica and teaching in order to improve the quality of clinical skills and consequently their clinical teaching. Mellish & Brink (1989:226) however, believe that the duration of clinical visits by nurse educators should be limited by pressure of their teaching programme. Such a programme in turn, must be carefully planned.

In another study conducted by Clifford (1996:604-605) in which nurse teachers' perception of their clinical role was explored, it still became obvious that clinical teaching was inadequate. Some nurse teachers admitted that their visits were

as short as two hours per week.

A question to be asked is: What are nurse educators actually doing when in clinical area? Lee (1996:1128) identified various functions that nurse educators engage in. These include student counselling, clinical supervision and contact with colleagues. In studies conducted by Gallego (1980) and Crotty (1993) as cited by Lee (1996:1129), nurse educators revealed that their role functions included marking, course planning, meetings and liaison. No mention of clinical activities done was made. It is therefore, doubtful that these nurse teachers do any direct demonstration to assist student nurses to gain nursing intervention skills.

2.9 REASONS FOR POOR/NON-INVOLVEMENT OF NURSE EDUCATORS IN CLINICAL TEACHING

In previous studies conducted by Cele (1990) and Mhlongo (1994), ward sisters stated that one of the major problems they experience in clinical areas is non-involvement of tutors in clinical teaching. The question to be asked is why nurse educators distance themselves from this important task? Several reasons are advanced by various authors.

2.9.1 LACK OF FORMAL TRAINING FOR CLINICAL TEACHING

2.9.1 MULTI DIMENSIONAL ROLE OF NURSE TEACHERS

Fulfilment of multiple roles is a social norm for all adults. It is a normality that a college tutor has a two fold function which is classroom and clinical teaching. In addition to these, university lecturers have several other tasks that have to be fulfilled. These include:-

- * research in clinical and academic matters
- * publishing
- * involvement in community-based projects

The nurse educator therefore has interrelated roles of teacher, clinician, researcher, mentor counsellor, consultant, liaison and evaluator (Kopala 1994:237; Myrick 1991:44). To further affirm the forementioned tasks, Parker

(1994:411) mentions teaching, scholarly work and community service as three expectations for promotion and tenure. This obviously means that qualification, alone are not enough for promotion.

Multiplicity of the nurse educator's role leads to role overload. Teaching personnel are further burdened with setting examinations, marking, preparing memoranda and scholarly activities such as counselling students and giving tutorials (Mhlongo 1994:4). She further asserts that there is no time for a well coordinated and well thought-out programme for clinical instruction. Nurse educators also perceive themselves as overloaded because they are expected to teach in classroom and in clinical area; do research and publish research findings. They are also expected to engage in community outreach programmes (Mashaba 1994:315). Possibly this is the reason why some nurse teachers forsake clinical instruction in order to fulfil these other functions.

Cele (1990); Fawcett & McQueen (1994); Karuhjie (1994); Mashaba (1994), Myrick (1991) and Woodrow (1996) further advance the following as reasons for poor clinical teaching by nurse educators:-

2.9.2 LACK OF FORMAL TRAINING FOR CLINICAL INSTRUCTION

A study on the nurse educators' perception of educational preparation for clinical teaching was done by Karuhjie (1994:142). Findings revealed a need for change and improvement in the preparation of nurse educators especially in clinical teaching competence. This is further endorsed by Mashaba (1994:52) when she points out that during educational preparation of nurse tutors, emphasis is placed on good classroom teaching.

It is not surprising, then, to observe that when nurse educators are faced with a load of work, clinical teaching takes low priority and it is easily shirked without any remorse. It is because of this neglect that Cele (1992) refers to clinical teaching as an "orphan", belonging to everyone in general and no one in particular.

2.9.3 LACK OF CLINICAL CREDIBILITY

An educator who lacks skills and confidence cannot instruct because she is not clinically credible. Webster (1990) as cited by Lee (1996:1132) describes clinical credibility to mean keeping up-to-date with current nursing practice so that what is taught in theory relates to what is carried out in practice. She further recommends that nurse educators must be involved in actual patient care and ward activity. Maintenance of clinical competence and bridging of the gap between theory and practice can thus be ensured. Involvement in actual patient care by nurse educators can be effected by "moonlighting", part-time employment in patient care situations or by undertaking to work on a voluntary basis during vacation or an academic recess. Nurse educators do work in hospitals, long term care, home care and community agencies (Strader & Decker 1995:74). Clinical credibility is as important as educational credibility (Croft 1993 in Mashaba 1994:59). It is perhaps why Karuhjie (1986:142) believes that clinical teaching demands that a nurse educator should have competence in both nursing and in teaching. This is crucial if clinical credibility has to be maintained.

2.9.4 NEGATIVE ATTITUDE

Some nurse educators shun clinical in preference to classroom teaching. This may be due to a low status given to clinical teaching. Myrick (1991:44) believes that this particularly affects university nurse educators because the culture within their work setting fosters research, publishing and community work as priorities. She further points out that some nurse educators focus on functions that ensure academic survival because choosing clinical instruction means risking academic demise since it gives one no academic credits. The situation in colleges is, however, different because most nurse tutors take clinical teaching as part of their day to day work.

Karuhjie (1986) as cited by Parker (1994:411-412) points out that clinical teaching is not a cherished and sought-after assignment as it is viewed as a form of punishment. This is so because senior nurse educators expect to be relieved

of clinical assignments so they can pursue their scholarly activities (de Tornyay & Thompson 1987:).

Castledine (1994:1000) encourages nurse educators to acknowledge advantages of having nursing education being absorbed into the main stream education system. He warns, however, that nurse educators should not adopt values and demands of academic life at the expense of clinical teaching.

2.10 THEORETICAL FRAMEWORK FOR THE STUDY : ROLE THEORY

2.10.1 INTRODUCTION

This study is based on role theory. It was chosen on the basis that it focuses on interpersonal interaction and interpretation of behaviour within institutions where actors perform their role. It deals with the prediction of how actors will perform in any given role. It also looks at circumstances under which certain behaviour may be expected (Hardy & Conway 1978:17).

Merton (1957:368) states that a part that a person plays (role) and the position he occupies (status) in the process of interaction, form the core of role theory.

2.10.2 BASIC CONCEPTS OF ROLE THEORY:

2.10.2.1 CONCEPT STATUS

Status is the position an individual or group holds/occupies within a social structure, applicable to a given situation. Status establishes rights and obligations with reference to others holding positions within the same social structure (Biddle & Thomas 1966:67). In this study, status will mean position occupied by the nurse educator within a clinical teaching setting in relation to other people who exist and function within the same situation. The people she interacts with are student nurses who occupy positions as learners. Both nurse educators and students have rights and

obligations within the structure. Students on the one hand are in need of help and accompaniment while they are obliged to co-operate and work diligently. The nurse educator, on the other hand is obliged to show students how to nurse and become professionals (Abraham & Shanley 1992:72).

Two types of statuses are described by Biddle & Thomas (1966). One is ascribed and the other achieved. Ascribed status is a position given to an individual by virtue of his race, kinship, sex or age. A child may, for instance, in a caste system, take the status of a parent and become king. This happens irrespective of his capabilities, limitations and ability to achieve (Biddle & Thomas 1966:69-72). Status may be achieved through hard work, talent, studying hard and exerting one's self in order to achieve a desired position in society. This type is not just given but a person achieves it through normative, subordination and superordination of other members of different statuses within the group (Hooper 1981:142-144). As Schlenkler (1985:178) points out, status within a group gives powerful advantages to a person having it, for instance the ability to influence other people.

Benoit (1966) as cited by Biddle & Thomas (1966:78-79) describes status as something prestigious because of its characteristics. He maintains that a person of status is all of the following:-

- * an object of admiration
- * an object of deference
- * an object of attraction
- * a centre of attraction
- * an object of imitation; and
- * a source of suggestions

The nurse educator's position in the teaching situation reflects all of the foregoing features of status. As a role model, clinician, and teacher, she

is admired, imitated and is used as a resource person by her students. She is also treated with respect as a person of superior knowledge.

2.10.2.2 CONCEPT ROLE

Role is closely related to status. It refers to functions that define a person's status, occupation and behaviour in a specific society (Menard 1987:10). Jordaan & Jordaan (1984:671) define role as rule - following patterns of action carried out in particular situations in relation to others who, in turn, also fulfil a role. Hardy & Conway (1978:75) point out that role refers to both actual and expected behaviours associated with a position.

For the purpose of this study, role refers to the ideal as well as the actual activities that nurse educators carry out towards nursing students' education and training in relation to clinical instruction. During performance of a role, interaction takes place between individuals, that is, teacher and student. This constitutes role relations and role obligations. The interaction occurs within traditions and norms (rule-following patterns of action) of the nursing profession.

As Strader & Decker (1996:58) points out, role has two components:-

- norms which are general expectations of a role, and
- values which represent attitudes and beliefs of an individual about the role behaviours.

This implies that nurse educators should abide by certain expected rules when performing a role. Such performance is largely influenced by attitudes and beliefs in relation to the particular role, that is, the way they perceive a particular role.

2.10.2.3 CONCEPT ROLE PERFORMANCE

This is also called role enactment or role behaviour. Behaviours and activities carried out by a person in specific situations constitute role. Role performance is goal-directed, overt action that has been learned

previously (Hardy & Conway 1978:76; Biddle & Thomas 1966:193). All individuals in society occupy roles. Several factors that influence role performance are identified by Biddle & Thomas (1966:4). These include social norms, demands and rules, the individual's own capabilities and personality as well as individuals who observe and react to the performance. One's role performance is also influenced by how others perform their roles in their respective positions in relation to one.

Authors of the role theory acknowledge that role performance can lead to the followings among other things:-

ROLE STRESS

Role stress is a social structural condition in which role obligations are vague, irritating, conflicting or impossible to meet (Hardy & Conway 1978:76). Role stress manifests itself when there is role ambiguity, strain and conflict (Mhlongo 1994:17). Hardy & Conway (1978:81-85) identify several types of role stress. These include:-

ROLE AMBIGUITY

This is a situation where there is a lack of clarity on role expectations and demands. Role expectations are vague, ill-defined and unclear. The role occupant becomes uncertain about expectations and this may lead to role conflict. Role ambiguity and contradiction in role-related obligations can also lead to role strain (Abraham & Shanley 1992:231).

ROLE CONFLICT

This occurs when an individual is confronted with clear but conflicting role expectations and demands (Fain 1987:232). It also means exposure of an actor to conflicting sets of legitimized role expectations to an extent, that fulfilment of all role expectations is relatively impossible (Hardy & Conway 1978:275). Pennebaker (1994:219) believes that role conflict arises from competing demands which may even be incompatible.

ROLE OVERLOAD

This is where a role occupant is confronted with excessive demands which he cannot adequately fulfil. Poor fulfilment of a role may be due to lack of time and not ability to perform each role competently. Role overload is a known phenomenon in nursing education. Mashaba (1994:315) indicates that nurse educators feel overloaded because while they are expected to teach in classroom and clinical area, they are also to do research, publish and at the same time participate in community outreach programmes.

ROLE STRAIN

Role strain is the subjective state of distress experienced by a role occupant when exposed to role stress (Hardy & Conway 1978:76). Biddle & Thomas (1966:62) define it as felt difficulty in fulfilling role obligations. This results from lack of resources, demands to plan for too many role (role overload) or role that is too complex (Martin 1989:59).

2.10.2.4 ROLE-TAKING

Role taking is the capacity to take the role of the other (Hardy & Conway 1978:76). This according to Morrall (1995:136) suggests that roles are prescribed and defined by specific sets of rules which all actors comprehend and to which they conform. According to Morrall (1994:136), role taking occurs through imitation of other people's actions during interaction. Role taking may proceed from observing a segment of behaviour to identifying the feelings or motives behind the action. During role taking, a student imitates another's behaviour. Nurse educators, therefore, need to be mindful of the way they model for students who are getting ready to take on the role of a professional nurse. It is for this reason that Hardy & Conway (1978:24) suggest that role taking is taking of attitudes of others who are involved in an interaction.

2.10.3 APPLICATION OF ROLE THEORY TO THE STUDY

Role theory is relevant to this study because it focuses on person to person interaction with regard to fulfilment of role obligations. It also focuses on how human behaviour can be interpreted within certain circumstances where people perform their role. This, in a student-teacher situation, enables nurse educators as role models to interpret the meaning of their behaviour and the influence it has on the student nurses who are observing their performance and reacting by role taking.

Role theory explains and describes people's behaviour in any given interpersonal encounter. It therefore conscientises nurse educators about their role as professionals and persons. As Fain (1987:233) correctly points out, nurse educators are nurses before they adopt the second profession which is teaching. They need to be aware therefore, that in order to teach well in class they have to be nurses and accept themselves as such.

Being a nurse educator signifies a particular status within a profession which is a social structure. The status that nurse educators have, is not, automatic and ascribed, but it is achieved through labour. Because status is accompanied by rights and obligations, it is achieved by conforming to expectations and fulfilling obligations. This role is learnt during the early days of training as a neophyte. Educating patients and other students is an obligation that nurse educators get oriented to. This is intensified when a nurse undertakes a diploma or degree course that will specifically lead to her getting registered as a tutor with the South African Nursing Council. The nurse educator's role therefore evolves from her nursing role.

Nurse educators learn their role (functions) during role-taking. According to Katz & Kahn's role-taking theory, several steps are involved in role-taking. They include:-

- Role sending

- Which constitutes communication from the role set for the prospective nurse educator. This may either be direct information or influence that is meant to increase conformity to norms of the structure until she internalises the role.
- Role received
Relates to role expectations that are taken by the prospective role occupant
 - Role transition
Meaning the actual learned behaviour appropriate to a position being occupied (Strader & Decker 1995:59). The performance of such a role is influenced by many factors such as nature of preparation to take the role, personal enthusiasm and the motive behind becoming a tutor.

Role taking can either be successful or unsuccessful. If it is successful, the educator accepts her teaching role as a package, that is, teaching in class, in clinical area and clinical research. A tutor status in nursing education is a prestigious one and is accompanied by benefits such as comfortable working hours and popular leave months of the year. If role performance does not occur as expected, it indicates that role transition has been unsuccessful and ineffective.

A consequence of poor role taking may be role distancing. Goffman (1961) in Abraham & Shanley (1992:75) explains this as a process by which a person indicates to others that there is more to his/her life than the particular role. This is done to reduce and undermine the unwanted role. He further points out that role distancing occurs when a person steps out of her real role into another set of rules. The nurse teacher experiences such a transaction when she leaves a nursing role and adopts a teaching role, especially at an institution that has a different set of values.

The nurse educator ends up having role overload, because of the demands of her two-dimensional role. She is expected to fulfil demands of her nursing role which she cannot shirk and a teaching role that she is also expected to execute well. If these roles are perceived by the nurse educator as mutually exclusive, she then experiences role conflict. The role that is considered as unimportant and uncomfortable especially if it gives no credits within her social structure, is likely to be sacrificed.

ROLE PERCEPTION

Role perception encompasses the way that the role occupant believes a role should be enacted (Pennebaker 1994:219). This confirms an assertion by Morrall (1962) in Clifford (1996:1135) that role evolves from role perception and role enactment. This implies that the way a nurse educator perceives her clinical instruction role influences and is reflected in the way she actually carries out her obligations. Socialising a nurse, therefore, into a nurse educator's role depends on the way in which clinical teaching is perceived.

2.11 CONCLUSION

The foregoing discussion explains nurse educators' multiple role obligations. Multiplicity of their role can either lead to role fulfilment and job satisfaction or role distancing, role strain and role conflict. Data analysis in Chapter 4 will be anchored on the discussion presented above.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

This chapter focuses on the discussion of methods used to meet the objectives of this study. It includes a research design, population and sample, research instrument, data collection method and data analysis plan. Research method according to Polit & Hungler (1983:532) means steps, procedures and strategies used for gathering and analysing data in a research investigation.

3.2 RESEARCH DESIGN

The research design in this study was the cross-sectional descriptive survey. A cross-sectional descriptive survey collects data from a cross-section or a presumably representative segment of a population at one point in time (Grimm & Wozniak 1990:233). It was chosen so that views and perceptions of nurse educators in respect of their role in clinical teaching could be explored. According to Polit & Hungler (1983:156), a survey also helps to collect information about people's opinions, attitudes and values.

3.3 SCOPE AND DELIMITATION

The KwaZulu-Natal province has been divided into eight (8) interim health regions from region A to H (see figure 3.1). These interim structures may be reduced or eliminated in future when district structures are well established (Owen 1995:54). This study was conducted in regions F and H.

Region F has six (6) nurse education and training institutions with a nursing college status. They are listed hereunder with an assigned code for each, for subsequent reference:-

Addington Nursing College	=	A
King Edward VIII Nursing College	=	B
R K Khan Nursing College	=	C

St Augustines' Nursing College	=	D
St Aiden's Nursing College	=	E

The first three administratively belong to the Natal Nursing College and the last two are private institutions. Prince Mshiyeni Nursing College at Umlazi (Code F) was also targetted but was not accessible since permission was not obtained. In addition to these colleges, region F has the University of Natal, Nursing Science Department (Code G) which also offers the basic baccalaureate curriculumis (B Cur) course.

Institutions that were under study in region H were Ngwelezana Nursing College (Code H) and University of Zululand, Nursing Science Department (Code I). Both are situated north of Tugela River. Ngwelezana Nursing College is 5 kilometres from Empangeni and has two satellite campuses that were excluded from the study since they fell outside the demarcated project area. One is Charles Johnson Memorial (Nqutu) in region G and the other was Benedictine Nursing College in Nongoma (region D). The University of Zululand (Main Campus) is situated in KwaDlangezwa, 19 kilometres south Empangeni and 142 kilometres north of Durban.

The rationale behind focusing on these regions is based on the researcher's previous and current clinical experience. The researcher has previously been a student, professional nurse and later a nurse tutor in some of the institutions in region F. She has also been and is currently exposed to the nature of nurse education and training in region H.

PROVINCE OF KWAZULU-NATAL PROPOSED HEALTH REGIONS

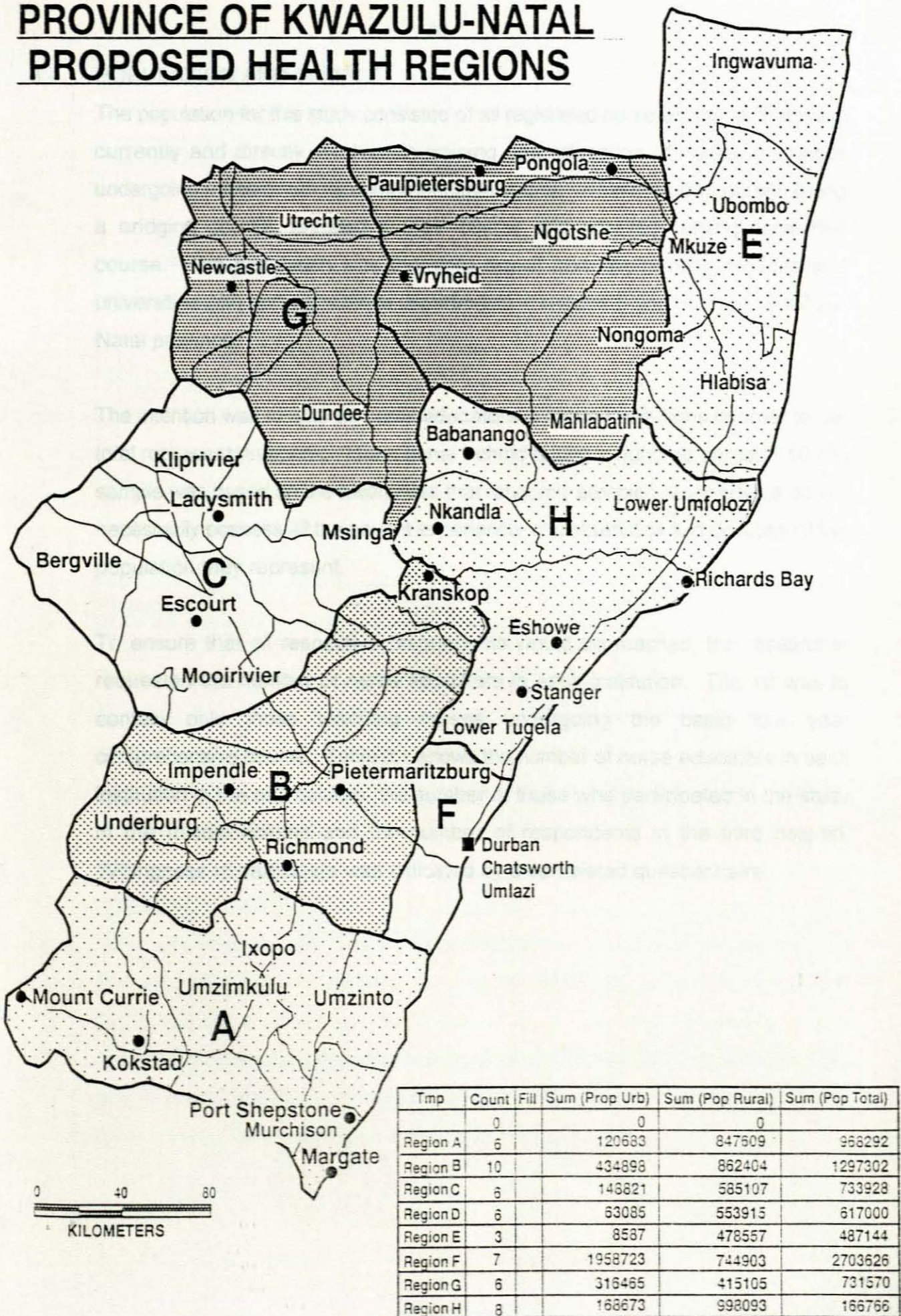


figure 3.1 MAP OF KWAZULU-NATAL PROVINCE

TABLE 3.1 NUMBER OF AVAILABLE AND RESEARCHED NURSE EDUCATORS IN INSTITUTIONS UNDER STUDY

INSTITUTION	NUMBER OF NURSE EDUCATOR	NUMBER OF RESEARCHED EDUCATORS	NUMBER OF RESPONDENTS
A Nursing College	16	16	14
B Nursing College	19	17	16
C Nursing College	17	17	17
D Nursing College	5-2 Pilot	2	2
E Nursing College	4	4	2
F Nursing College	-	-	-
G Nursing Science Dept	2	2	2
H Nursing Science Dept	11-3 Pilot	9	9
I Nursing College	14	11	10
TOTAL	89	78	72

Seventy two (72) out of seventy eight (78) nurse educators complete the questionnaire, giving a response rate of 92.3%. Five nurse educators were excluded from the main study because they participated in the pilot study. Three were from the indicated nursing college and two were from the indicated nursing science department.

3.5 RESEARCH INSTRUMENT

Data was collected by means of a questionnaire. A questionnaire allows for gathering of self-report information from respondents through self-administration of questions in paper-pencil format (Polit & Hungler 1983:535). The questionnaire was chosen because it also allowed respondents to respond as openly and as frankly as possible to the questions. An interview would probably have limited such openness if it had been used.

The questionnaire consisted of two sections:-

Section A consisted of biographic data, nursing educational data and professional status data.

Section B had open and close-ended questions on the nature, frequency and activities of nurse educators in relation to clinical instruction participation. It also contained a double-barrel type of Likert Scale. This was similar to the one developed by Brink (1984) in structure but not in content. Using the instructional process system approach, statements were developed to elicit nurse educators' perception of their ideal (what ought to be) and their actual (what is actually done) clinical instruction role. Such an approach would enable the researcher to determine incongruency, if any, between what nurse educators should do and what they actually carry out. The statements were given on a 5 point (1-5) rating scale (strongly disagree to strongly agree in "ideal" scale and not at all to great deal in "actual" scale).

One part of the scale (ideal) was meant to get information relating to the extent to which nurse educators perceived the listed activities as their ideal functions. The other (actual) elicited information about actual activities that nurse educators engage in while in clinical area.

3.6 PRETESTING OF THE INSTRUMENT (PILOT STUDY)

The questionnaire was pretested before being distributed to respondents for the main study. The intention was to identify weaknesses in the instrument and to determine if questions and instructions were clearly stated. A pilot study is necessary as it assesses the adequacy of the data collection plan (Polit & Hungler 1983:39). It enables the researcher to make improvements where necessary, before the principal study is done.

The questionnaire was tested on five nurse educators i.e. two at the University of Zululand and three at St Augustine's nursing college. From a sampling frame of eleven (11) nurse educators at the University of Zululand the researcher selected, every third name was selected i.e. 3, 6, 9. From a list of five at St

Augustine's Nursing College, every second name was selected to get two nurse educators for the pilot study. The subjects were requested to note any problems in the phrasing of statements and instructions. They were also to note the time taken to complete the questionnaire. The duration differed from 20-25 minutes. A discussion was also held with Professor T.G. Mashaba, promoter and renown nurse educator.

Some minor alternatives were recommended in section two of the questionnaire. The instrument was then refined before being administered for the main study. None of the five pre-mentioned subjects were included in the main study.

3.8.2 CONFIDENTIALITY AND ANONYMITY

3.7 VALIDITY OF THE RESEARCH INSTRUMENT

Validity refers to the degree to which a research instrument measures what it is intended to measure (Polit & Hungler 1983:538). Reviewed literature made it possible to establish content validity of the questionnaire. It provided information on the role of the nurse educator and information related to clinical teaching. During the pilot study, items were examined by nurse educators to see if questionnaire items would address the research question and objectives of the study. This was intended to establish if items in the questionnaire measured what they were supposed to measure i.e. what nurse educators perceive as their clinical instruction role.

3.8 ETHICAL CONSIDERATION

Research on human subjects requires that certain ethical precautions be taken.

3.8.1 PERMISSION TO CONDUCT RESEARCH

Permission to conduct research was sought and obtained from the Director General, Department of Health in Pietermaritzburg. This related to institutions belonging to the Natal Nursing College that were geographically located in Region F i.e. A, B and C. Thereafter, campus principals, as per conditions laid down by Director General, were consulted individually to gain access into each institution (See Annexure C).

To conduct research in the independent private institutions like St Augustine's and St Aiden's Nursing Colleges, the researcher asked for permission from the respective principals. Furthermore, heads of departments of the University of Zululand and Natal granted permission to the researcher (See annexures D,E,F,G and H)

The questionnaire bore a covering letter requesting prospective respondents' participation in the study. Completing and returning the questionnaire served as implied consent to participate.

3.8.2 CONFIDENTIALITY AND ANONYMITY

The researcher explained the nature and purpose of the study through telephonic and verbal contacts in addition to request letters. Requests were made to address nurse educators during office hours. In some institutions, nurse educators were addressed as a group and in others the explanation was given to Principals and Vice Principals who then distributed questionnaires to colleagues. Prospective respondents were assured that confidentiality would be maintained. To ensure anonymity, prospective respondents were requested not to write their names anywhere on the questionnaire.

3.9 DATA COLLECTION PROCEDURE

Questionnaires were distributed and collected by the researcher. At some institutions the questionnaires were left with the prospective respondents to be collected at a later date from the campus or deputy principals for convenience and control. At other institutions, questionnaires were filled by respondents in the quietness of their offices while the researcher waited in the department.

Most respondents took 20-35 minutes to complete the questionnaire. A second round of questionnaire distribution was done at institution B because the previous ones were reported to have been misplaced or lost by prospective respondents.

Response was satisfactory. The total number of eligible nurse educators in the

eight institutions where research was carried out, was eighty nine (89). Some nurse educators in institutions B and H did not take the questionnaires and therefore excluded themselves from the study. Table 3.2 shows the total number of questionnaires that were distributed, returned, usable and non-usable.

TABLE 3.2 RESPONSE TO DISTRIBUTED QUESTIONNAIRES

	NUMBER	PERCENTAGE
Distributed	78	100
Returned	72	92,3
Non-return	06	7,7
Usable	70	89,7
Non-usable	02	2,6

Reasons for the non-return of the six questionnaires were not established. After four personal visits to institution B and several telephonic reminders, the researcher failed to retrieve the distributed questionnaires. The researcher had to assume that the non-return was due to unwillingness to participate.

Two (2) questionnaires could not be used. One had more than one response (X) where only one was expected, that is the gender and age items. One (1) had responses to close-ended questions and most open-ended questions were left unanswered. These were therefore considered as incomplete.

3.10 CODING AND PLAN FOR ANALYSIS

The completed usable questionnaires were coded by the researcher with the assistance of the statistician. The open-ended questions were analysed manually. The close-ended items in the Likert-type scale were analysed using a computer by means of a statgraphics programme.

3.11 CONCLUSION

This chapter discussed the research design, scope of study, population and sample, research instrument, ethical considerations, data collection, coding of questionnaire items are plan for analysis.

CHAPTER 4

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

This chapter presents presentation, interpretation and discussion of findings of the analysed data from nurse educators who participated in this study. Analysis of open-ended questions was done manually and close-ended questions were analysed by means of a statgraphics programme. The data will be presented in the form of tables, pies and bar graphs.

4.2 SECTION A

4.2.1 BIOGRAPHIC DATA

4.2.1.1 ITEM 1.1 GENDER

Table 4.1 shows that out of seventy nurse educators who participated in this study, sixty five (92,9%) were female and five (7,1%) were male.

TABLE 4.1 GENDER OF PARTICIPANTS (N = 70)

GENDER	FREQUENCY	PERCENTAGE
Male	05	7,1
Female	65	92,9
TOTAL	70	100

These findings support the generally held view that nursing is a female-dominated profession. They compare with results of a study conducted by Mashaba (1986:16) on the socio-economic status of black students and its implication for nursing education. Of the one hundred and eighty (180) respondents, ninety one percent (91%) was female and nine percent (9%) was male.

A study conducted by Brink (1984:124) on the registered nurse tutor in the

Republic of South Africa, yielded a somewhat similar picture. Out of two hundred and thirty three (233) respondents two hundred and twenty (94,4%) were female and thirteen (5,6%) were male.

4.2.1.2 ITEM 1.2 AGE GROUP

As illustrated in Table 4.2, thirty (42,2%) respondents fell into the age group of 35-44 followed by seventeen (24,3%) who fell into the age group of 45-54. Only six (8,5%) respondents were below the age of 25 years.

TABLE 4.2 AGE DISTRIBUTION OF NURSE EDUCATORS (N = 70)

AGE GROUP	FREQUENCY	PERCENTAGE
Below 25	06	8,5
25 - 34	08	11,4
35 - 44	30	42,9
45 - 54	17	24,3
55 and above	09	12,9
TOTAL	70	100

The fact that the majority of nurse educators in this study fell into the age groups of 35-44 and 45-54 years is an indication that they are probably personally and professionally mature. Such nurse educators are expected to have enough knowledge and expertise to effectively guide student nurses in their clinical practice.

4.2.2 NURSING EDUCATIONAL DATA

4.2.2.1 ITEM 2.1 BASIC NURSING PROGRAMME UNDERGONE

The responses to Item 2.1 revealed that the majority of participants in this study undertook the South African Nursing Council Diploma as their basic programme as indicated in Table 4.3 below.

TABLE 4.3 BASIC NURSING PROGRAMME UNDERTAKEN (N = 70)

PROGRAMME	FREQUENCY	PERCENTAGE
S.A.N.C. Diploma	54	77,1
Nursing College Comprehensive Course	06	8,6
University Bachelor degree	09	12,9
Other	01	1,4
TOTAL	70	100

Table 4.3 indicates that fifty four (77,1%) respondents indicated that they completed the S.A.N.C. diploma, nine (12,9%), a university baccalaureate (B Cur) programme and six (8,6%) underwent the nursing college comprehensive course. Only 1 (1,4%) indicated her programme as having been other. No mention, however, was made of the type of programme completed.

These findings are not surprising considering that it was only in February 1985 that the S.A.N.C. promulgated R425 of February 1985 as amended. This regulation phased out the three year diploma and introduced the four year comprehensive course that could either be undertaken at a nursing college or university. This course would lead to registration as a nurse (general, psychiatric and community) and midwife (R425 of February 1985) as amended.

The majority of these nurse educators then, qualified as tutors at the time when there were clinical instructors that were specifically employed for clinical instruction. This could influence the way they perceive their role in clinical instruction.

4.2.2.2 ITEM 2.2 PROGRAMME COMPLETED FOR REGISTRATION AS A NURSE TUTOR

Out of seventy (70) nurse educators who responded to this item, thirty seven (52,8%) did a university diploma, twenty eight (40%) obtained their tutor registration through a post-registration university bachelor degree. Three (4,3%) did an additional single subject after a degree and two (2,9%) did not respond to this item.

TABLE 4.4 PERCENTAGE DISTRIBUTION OF PROGRAMME UNDERTAKEN FOR REGISTRATION AS A NURSE TUTOR (N = 70)

RESPONSES	FREQUENCY	PERCENTAGE
University Diploma	37	52,8
Post-registration Bachelor Degree	28	40
Single subject after degree	03	4,3
No response	02	2,9
TOTAL	70	100

It was pleasing to observe that the number of nurse educators who had undergone a post-registration university degree (28) was only less by (12,9%) than those who did a diploma (37). One assumed that a nurse educator who has done a degree in nursing education is more versatile and has a broader scope of knowledge than the one who did a diploma. Her broad scope of knowledge should enable him/her to cope with the challenge of educating and training the professional that the nursing profession aspires to produce.

4.2.2.3 ITEM 2.3 HIGHEST PROFESSIONAL QUALIFICATIONS OF NURSE EDUCATORS

TABLE 4.5 PERCENTAGE DISTRIBUTION OF HIGHEST PROFESSIONAL QUALIFICATION CURRENTLY HELD BY NURSE EDUCATORS (N = 70)

PROFESSIONAL QUALIFICATION	FREQUENCY	PERCENTAGE
Post-Basic Diploma	11	15,7
Bachelor degree	33	47,1
Honours degree	16	22,9
Masters degree	06	8,6
Doctoral degree	01	1,4
No response	03	4,3
TOTAL	70	100

As illustrated in Table 4.5, the highest percentage of respondents (47,1%) held a bachelor degree. Of the remaining 37 respondents, eleven (15,7%) held a post registration diploma, sixteen (22,9%) an Honours degree and six (8,6%) a Masters degree. Only one (1,4%) respondent held a doctoral degree. Three (4,3%) did not respond to the item.

4.2.3.2 ITEM 3.2 COURSES/SUBJECTS TAUGHT BY NURSE EDUCATORS

Such findings should be an indication that most nurse educators have been adequately prepared as nurses and as teachers. It is therefore expected that a nurse tutor of such educational and professional standing should recognise and accept her clinical teaching role.

4.2.3 PROFESSIONAL STATUS

4.2.3.1 ITEM 3.1 PROFESSIONAL TITLE

As depicted in Table 4.6, fifty six (80%) respondents were college tutors, two (2,8%) were principal tutors and twelve (17,1%) were university lecturers.

TABLE 4.6 PROFESSIONAL TITLE OF NURSE EDUCATORS (N=70)

RESPONSE	FREQUENCY	PERCENTAGE
Tutor	56	80
Principal Tutor	02	2,9
Lecturer	12	17,1
Professor	0	0
Other	0	0
TOTAL	70	100

Brink (1984:136) points out that the profession's expectation is that tutors have to be qualitatively prepared to enable them to equip future nurse practitioners. Such professional positions are therefore pleasing especially when viewed against the professional qualifications in item 2.3. Twenty three (32,9%) respondents had senior degrees, from an Honours to a doctoral degree. This is indicative of the nurse educators' keenness to accept the challenge of teaching. Their keenness is further confirmed by Brink (1984:165) in her study on the registered nurse tutor in the Republic of South Africa where the majority of tutors (93,2%) indicated that an interest in teaching was the prime motivator for undertaking a nurse tutors' course.

4.2.3.2 ITEM 3.2 COURSES/SUBJECTS TAUGHT BY NURSE EDUCATORS

This item was included to establish the basic nursing courses/subjects that were taught by nurse educators and required direct and constant clinical guidance.

TABLE 4.7 DISTRIBUTION OF COURSES/SUBJECTS TAUGHT BY NURSE EDUCATORS (N = 70)

SUBJECTS/COURSES					FREQUENCY	PERCENTAGE
General Nursing	Midwifery	Psychiatric Nursing	Community Health Nursing	No response		
*					15	21,4
	*				5	7,1
		*			4	5,7
			*		5	7,1
*	*				6	8,6
*		*			5	7,1
*			*		15	21,4
	*		*		3	4,3
		*	*		6	8,6
*		*	*		3	4,3
				*	3	4,3
TOTAL					70	100

Findings presented in Table 4.7 show that out of seventy respondents, fifteen (21,4%) taught general nursing only, while five (7,1%); four (5,7%) and five (7,1%) taught midwifery, psychiatric nursing and community health nursing respectively. Six (8,6%) nurse educators taught two subjects/courses each, that is general nursing and midwifery, and five (7,1%) taught general nursing and psychiatric nursing. Only three (4,3%) respondents indicated that they taught three courses/subjects which were general nursing, psychiatric nursing and community health nursing. Three (4,3%) did not give a response to this item.

Nurse educators are expected to assist students in the practice area with integration of theory and practice (Brink 1984:151). They are also to help with integration of various subjects taught to a nursing student. It is therefore pleasing to observe that forty one (58,6%) nurse educators taught more than one subject/course. This probably enables them to

teach at a more applied level than the twenty nine (41,4%) that taught only one subject/course.

4.3 SECTION B : PARTICIPATION OF NURSE EDUCATORS IN CLINICAL INSTRUCTION

4.3.1 ITEM 4.1 JOB DESCRIPTION FOR NURSE EDUCATORS

This item was included to establish if there existed a job description for nurse educators in the institutions under study. It also aimed at establishing duties that were specifically delegated to nurse educators.

Responses were many and varied. Some activities were specifically related to theory teaching. These included:-

- preparation of lessons/lectures
- setting tests and examinations and marking them
- designing and revising study guides
- lecturing and
- keeping records

Activities relating to clinical teaching included the following:-

- clinical allocation of students
- liaison with clinical staff
- clinical accompaniment
- clinical evaluation like participation in Objective Structured Clinical Evaluation (OSCE)
- student counselling

No mention, however, was made of the expected frequencies and duration of clinical teaching.

Ancillary duties that needed the attention of nurse educators were also mentioned:-

- selection and interviewing of students

- staff development
- ordering of textbooks for students
- maintenance of audio-visual aids

More academic expectations included researching, publishing and participating in community projects.

4.3.2 ITEM 4.2 PARTICIPATION IN CLINICAL INSTRUCTION

In this item the respondents were to indicate whether or not they participated in any clinical instruction. Figure 4.1 indicates that sixty five (92,9%) nurse educators responded that they participated and five (7,1%) said they did not.

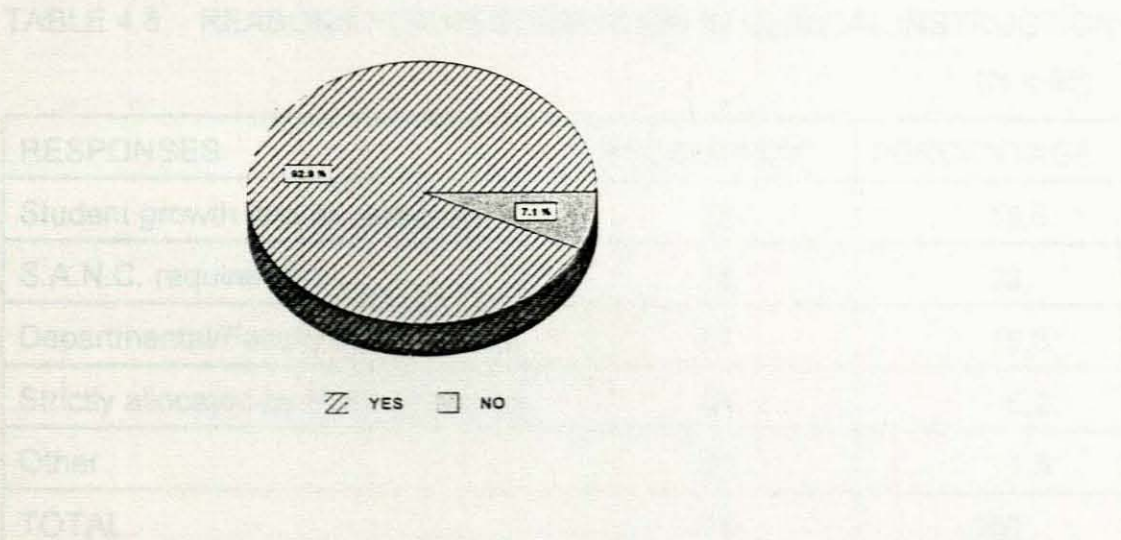


Figure 4.1 Participation and non-participation of nurse educators in clinical instruction.

It was disappointing to find that five (7,1%) respondents did not participate in clinical teaching. One would expect that all nurse educators are aware of the need to accompany student nurses in the clinical area. Such findings probably suggest that some nurse educators do not take the practical component of their subjects/courses seriously.

4.3.3 ITEM 4.3 REASONS FOR PARTICIPATION IN CLINICAL INSTRUCTION

This item was meant for respondents who indicated that they participate in clinical instruction. When requested to indicate their reasons for doing clinical

instruction, thirty eight (58,5%) indicated that it was necessary for student growth and development while fifteen (23%) said it was the S.A.N.C. requirement. Seven respondents (10,8%) did it because it was a requirement of the department, and four (6,2%) indicated that they were strictly allocated by Head of Department or principal tutor. Other reasons were "correlation of theory and practice, students need nurse educators in clinical areas and "telling what to do is never equivalent to showing how to do" (See Table 4.8). Smith (1977:72) agrees with these findings when she says clinical instruction has a particularly important influence, on the development of the students' values.

TABLE 4.8 REASONS FOR PARTICIPATION IN CLINICAL INSTRUCTION
(N = 65)

RESPONSES	FREQUENCY	PERCENTAGE
Student growth and development	38	58,5
S.A.N.C. requirement	15	23
Departmental/Faculty Requirement	07	10,8
Strictly allocated by Head of section	04	6,2
Other	01	1,5
TOTAL	65	100

4.3.4 ITEM 4.4 REASONS FOR NOT PARTICIPATING IN CLINICAL INSTRUCTION

In this item the five (7,1%) respondents that had indicated they were "not at all" participating in clinical teaching were further requested to indicate their reasons for not doing so. A list of statements was given and they had to indicate as many reasons as possible. Space was accommodated as "other" for additional reasons not given in the list.

Table 4.9 shows responses in order of priority as seen by respondents:-

- * overburdened with teaching duties was checked by all five (100%) while
- * lack of clinical skills and confidence was checked by four (80%) respondents

* lack of peer support was also given by four (80%) respondents.

Under "other", five (100%) respondents said clinical instruction gives no academic credits and is accorded low status while four (80%) stated that it is frustrating and stressful.

TABLE 4.9 REASONS FOR NON-PARTICIPATION IN CLINICAL INSTRUCTION (N = 5)

	1	2	3	4	5	6	7	8	9	10
Respondent 1	*				*	*				
Respondent 2	*					*				
Respondent 3	*				*					
Respondent 4	*				*	*				
Respondent 5	*				*	*				

KEY STATEMENTS:

- 1 = Overburdened with teaching duties
- 2 = Have subordinates to do it
- 3 = Not responsibility of nurse educator
- 4 = Do not like it
- 5 = Lack of clinical skills/confidence
- 6 = Lack of peer support in ward
- 7 = Do not feel it is necessary
- 8 = Not taught during role taking
- 9 = Other
- 10 = No response

4.3.5 ITEM 4.5 AVERAGE DURATION SPENT IN CLINICAL TEACHING

This item was specifically meant for nurse educators who indicated that they participate in clinical instruction.

TABLE 4.10 TIME SPENT IN CLINICAL TEACHING (N = 65)

RESPONSES	FREQUENCY	PERCENTAGE
1 - 2 Hours per week	13	20
3 - 5 Hours per week	26	40
6 - 8 Hours per week	16	24
More than 8 hours	8	13
No response	2	3
TOTAL	65	100

As illustrated in Table 4.10, twenty six (40%) respondents reported that they spent 3-5 hours per week in clinical area. Sixteen (24%) spent 6-8 hours and thirteen (20%) spent 1-2 hours. Only eight (13%) spent more than 8 hours. Two (3%) participants did not respond. Although most nurse educators did not indicate the number of hours they were to spend in clinical area according to their job description, fifty (76,9%) stated that they spent from 3 hours to more than 8 hours, an indication of some degree of commitment.

Opinions differ with regard to how long nurse educators should spend in clinical area. While Mason and Jinks (1994:1069) maintain that they must alternate periods between theory and practical teaching, their opinion is countered by a view that time spent in clinical area must be limited by the pressure of the nurse educators' teaching programme (Mellish & Brink 1989:226).

4.3.6 ITEM 4.5.1 MEASUREMENT OF TIME SPENT IN CLINICAL AREA IN RELATION TO JOB DESCRIPTION

This item was included to establish the nurse teachers' views on whether the time they spent in clinical teaching measured up to their job description. Figure 4.3 indicates that fifty five (84,6%) felt that this measured up to their job description and ten (15,4) said it did not compare favourably with their job description.

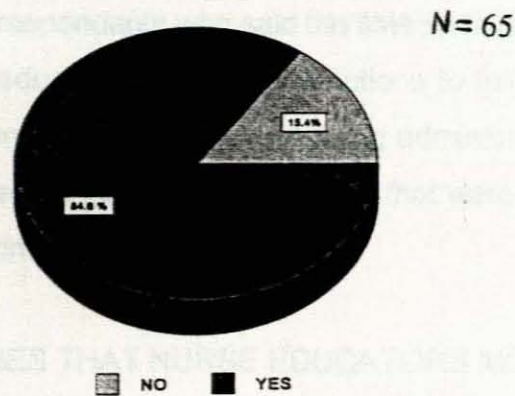


Figure 4.2 Responses to a measurement of time span in clinical area in relation to job description.

This is an indication that the majority of nurse educators were aware that they fell short of the expectations.

4.3.7 ITEM 4.5.2 ADEQUACY OF TIME SPENT IN CLINICAL AREA AND MOTIVATION

In this item, nurse educators were requested to indicate whether the time they said they spent in the clinical area was adequate in their opinion. They were further asked to motivate for their responses. Out of sixty five respondents, thirty five (53,8%) felt that the hours they spent in clinical area were enough while twenty five (38,5%) indicated that they were not enough. Five (7,7%) were unsure. They felt that the duration of clinical visits had to be determined by the presence or absence of blocks or examinations.

TABLE 4.11 ADEQUACY OF TIME SPENT IN CLINICAL AREA (N = 65)

RESPONSES	FREQUENCY	PERCENTAGE
Adequate	35	53,8
Not adequate	25	38,5
Unsure	5	7,7
TOTAL	65	100

The thirty five (53,8%) respondents who said the time span given in Item 4.5 was adequate, said nurse educators had many functions to fulfil like preparation of lectures, teaching theory, marking tests and doing administrative duties. It was pleasing, however, to learn that others had periods that were made available and actually slotted in the time table.

4.3.8 ITEM 4.6 ACTIVITIES THAT NURSE EDUCATORS MOSTLY ENGAGE IN DURING CLINICAL VISITS

As illustrated in Figure 4.3, out of seventy nurse educators, sixty four (91,4%) said teaching and guiding students and also evaluating students were activities they mostly engaged in. This was followed by accompanying students and role modelling for students which were checked by fifty three (75,7%) respondents each. Doing continuous assessment was checked by forty eight (68,6%) respondents while planning clinical learning programmes and designing of tools and procedures were checked by forty three (61,4%) respondents.

These findings are partly in keeping with those of the study conducted by Lee (1996:1130), on the clinical role of the nurse teacher : a review of the dispute. In this study, it was found that nurse educators were engaged in functions like:-

- * Counselling students;
- * Liaison with clinical staff, which meant maintaining good relationship and supporting clinical staff in their clinical instruction duties;
- * Supervising and teaching of students in clinical area; and
- * Assessment

Activities:

1. Planning clinical teaching programme.
2. Design tools and procedures.
3. Accompany students.
4. Evaluate students.
5. Teach and guide students.
6. Do continuous assessment.
7. Demonstrate nursing skills.
8. Role model for students.
9. Other.

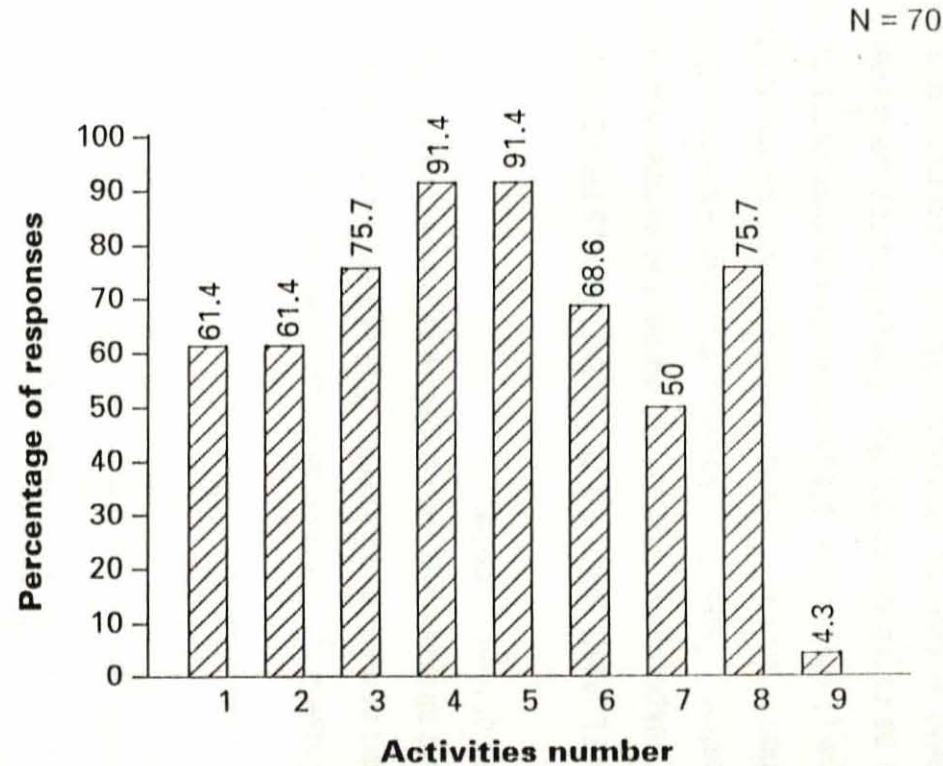


Figure 4.3: Percentage distribution of activities done by nurse educators during clinical visits.

4.3.9 ITEM 4.7 IS CLINICAL INSTRUCTION AN INTEGRAL PART OF NURSE EDUCATION

This item was aimed at establishing whether nurse educators perceived clinical instruction as part of nursing education.

TABLE 4.12 PERCENTAGES OF RESPONSES TO WHETHER CLINICAL INSTRUCTION IS AN INTEGRAL PART OF NURSING EDUCATION (N = 70)

RESPONSES	FREQUENCY	PERCENTAGE
Yes	62	88,5
No	2	2,9
Uncertain	6	8,6
TOTAL	70	100

From the responses in Table 4.12, it is apparent that nurse educators perceive clinical instruction as a part of nursing education. These findings are supported by Mashaba (1994:49) who stresses that it is obligatory for nurse tutors to feature in the clinical experiences of their students.

4.3.10 ITEM 4.8 PERSONNEL WHO SHOULD DO CLINICAL INSTRUCTION

This item was meant for respondents who did not agree that clinical instruction belongs to nursing education. Table 4.11 indicates that they were two (2,9%). Both said it was the function of clinical instructors who are there for this function on a full-time basis. One (1,4%) further alleged that clinical instructors do not have as many activities as nurse educators do. These findings contravene a statement by Searle (1985) as cited by Mhlongo (1994:21) who maintains that clinical teaching is first and foremost the responsibility of the tutor and, to a lesser extent, of the professional nurse in charge of the nursing unit who must accept responsibility for this.

4.3.11 ITEM 4.9 IDEAL DURATION FOR CLINICAL VISITS BY NURSE EDUCATORS

The respondents were asked to indicate how long, in their opinion, nurse educators should spend in the clinical area. The researcher was keen to establish if responses to this item would be congruent with those in Item 4.5 (Actual Time Spent).

Table 4.13 shows that nine (12,9%) respondents were of the opinion that 1-2 hours per week is enough while sixteen (24,3%) felt that nurse educators should ideally spend 3-5 hours per week in clinical settings. Twenty nine (41,4%) respondents however, believed that 6-8 hours would be an ideal duration and twelve (17,1%) for more than 8 hours per week.

TABLE 4.13 IDEAL DURATION FOR CLINICAL VISITS BY NURSE EDUCATORS

RESPONSES	FREQUENCY	PERCENTAGE
1 - 2 Hours per week	09	12,9
3 - 5 Hours per week	17	24,3
6 - 8 Hours per week	29	41,4
More than 8 hours	12	17,1
No response	03	4,3
TOTAL	70	100

From these findings, it appears that nurse educators spent less time in clinical area than they believe they should. Observing this discrepancy between what nurse educators perceived as an ideal time span and the actual time spent, made one to wonder if the statement made by Quinn (1980:396) is not true when she says:-

"It remains an anomaly within the system that nurse teachers can teach what they no longer practice."

4.3.12 ITEM 4.10 EXTENT TO WHICH NURSE EDUCATORS PERCEIVE CLINICAL INSTRUCTION ROLE AND EXTENT TO WHICH THEY ACTUALLY PRACTISE IT

This item was included to establish the extent to which nurse educators perceived the activities in the Likert-scale as their ideal functions and the extent to which they actually practised them. It was assumed that their perception of their role would largely influence the way they fulfilled their role functions. This information was elicited through a double-barrel Likert scale consisting of Scales 1 and 2 for ideal and actually practised activities respectively.

The scale had twenty four (24) statements that were grouped into four according to the steps of the instructional development process. Six items related to assessment in clinical instruction, five related to planning and implementation each and six were related to evaluation in clinical teaching. Two (2) items were added to determine if recording was done and what records were kept.

Respondents had to indicate by means of a cross (X) the extent to which they agreed that listed activities reflected their ideal and actual function in relation to clinical teaching. Analysed data was presented in the form of tables. To identify favourable and unfavourable responses, the response codes were horizontally collapsed into three classes. In the ideal scale, responses 1 (Strongly Disagree) and 2 (Disagree) were classified as "Disagree". Responses 4 and 5 (agree and strongly agree) respectively, were classified as "Agree". Class three, "Uncertain" was formed by uncertain and no response.

In the actual scale, responses 1 (Not at all) and 2 (Minimally) were classified as "Non-participating" responses. Responses 3 (Reasonably), 4 (Considerably) and 5 (Great Deal), were categorised as "Participating". "No response" formed the third class.

4.3.13 ITEM 4.10.1 IDEAL AND ACTUAL EXTENT OF PARTICIPATION IN ASSESSMENT PHASE OF CLINICAL INSTRUCTION BY NURSE EDUCATORS

This item was included to determine the ideal and actual extent of participation of nurse educators in activities associated with assessment.

RESPONSES TO ACTIVITY 4.10.1.1 : ASSESSMENT OF STUDENTS' LEARNING NEEDS

Table 4.14 and Figure 4.4 on the ideal scale show that sixty one (87,1%) respondents agreed that this was a nurse educator's function while only two (2,9%) gave a negative response. Seven (10%) participants did not respond to this item.

This was a pleasing finding because it indicated that nurse educators are aware that the effect of instruction will depend on prior knowledge of the learner, his weaknesses and potentials. Van Hoozer et al (1989:83) recommend that nurse educators should take cognisance of factors such as motivation, achievement and previous grades of the student.

This finding confirmed a statement made by Reilly & Oermann (1985:99) that assessment is an important step in the instructional process. They further assert that this assessment does not only help with determining the entry behaviour of the student but also with identification of deficiencies that will need attention during instruction.

As reflected in Figure 4.4 (Actual Scale) fifty one (72,9%) respondents indicated that they were actually participating in assessing learning needs of students while eighteen (25,7%) said they did not. This finding compares poorly with the finding in the ideal scale. Assessment should help the nurse educators to determine the competence level of the student which in turn forms the starting point of the instructional process.

TABLE 4.14 PERCENTAGE DISTRIBUTION OF RESPONSES OF NURSE EDUCATORS TO IDEAL AND ACTUAL EXTENT OF INVOLVEMENT IN ASSESSMENT ACTIVITIES FOR CLINICAL INSTRUCTION N = 70

ACTIVITIES	IDEAL SCALE						ACTUAL SCALE						
	SD	D	U	A	SA	NR	1	2	3	4	5	NR	
ASSESSING													
1. Learning needs of students	0 0%	2 2,92%	6 8,6%	27 38,6%	34 46,6%	1 1,4%	5 7,1%	13 18,6%	27 38,6%	15 21,4%	9 12,9%	1 1,4%	
2. Need to get clinically involved	1 1,4%	0 0%	11 15,7%	36 51,4%	22 31,4%	0 0%	3 4,3%	21 30%	22 31,4%	16 22,9%	8 11,4%	0 0%	
3. Nature of accompaniment	0 0%	1 1,4%	16 22%	34 48,6%	17 24,3%	2 2,8%	7 10%	15 21,4%	29 41,4%	13 18,6%	4 5,7%	2 2,9%	
4. Relevance of content in relation to level	0 0%	0 0%	5 7,1%	39 55,7%	24 34,3%	2 2,8%	6 8,6%	11 15,7%	28 40%	16 22,9%	9 12,9%	0 0%	
5. Availability of resources for clinical teaching	3 4,3%	3 4,3%	11 15,7%	31 44,3%	20 28,5%	2 2,8%	3 4,3%	3 4,3%	22 31,4%	30 42,9%	10 14,3%	2 2,9%	
6. Suitability of placement in relation to level	0 0%	0 0%	3 4,3%	40 57,1%	25 35,7%	2 2,9%	10 14,3%	10 14,3%	22 31,4%	23 32,9%	3 4,3%	2 2,9%	

KEY:

IDEAL SCALE
 SD = Strongly Disagree
 D = Disagree
 U = Uncertain
 A = Agree
 SA = Strongly Agree

ACTUAL SCALE
 1 = Not at all
 2 = Minimally
 3 = Reasonably
 4 = Considerably
 5 = Great Deal
 NR = No response

- Activities:**
- Assessment of:**
1. Learning needs of students.
 2. Need to get clinically involved.
 3. Nature of clinical accompaniment.
 4. Relevance of content to level.
 5. Availability of resources for clinical instruction.
 6. Suitability of placement in relation to level.

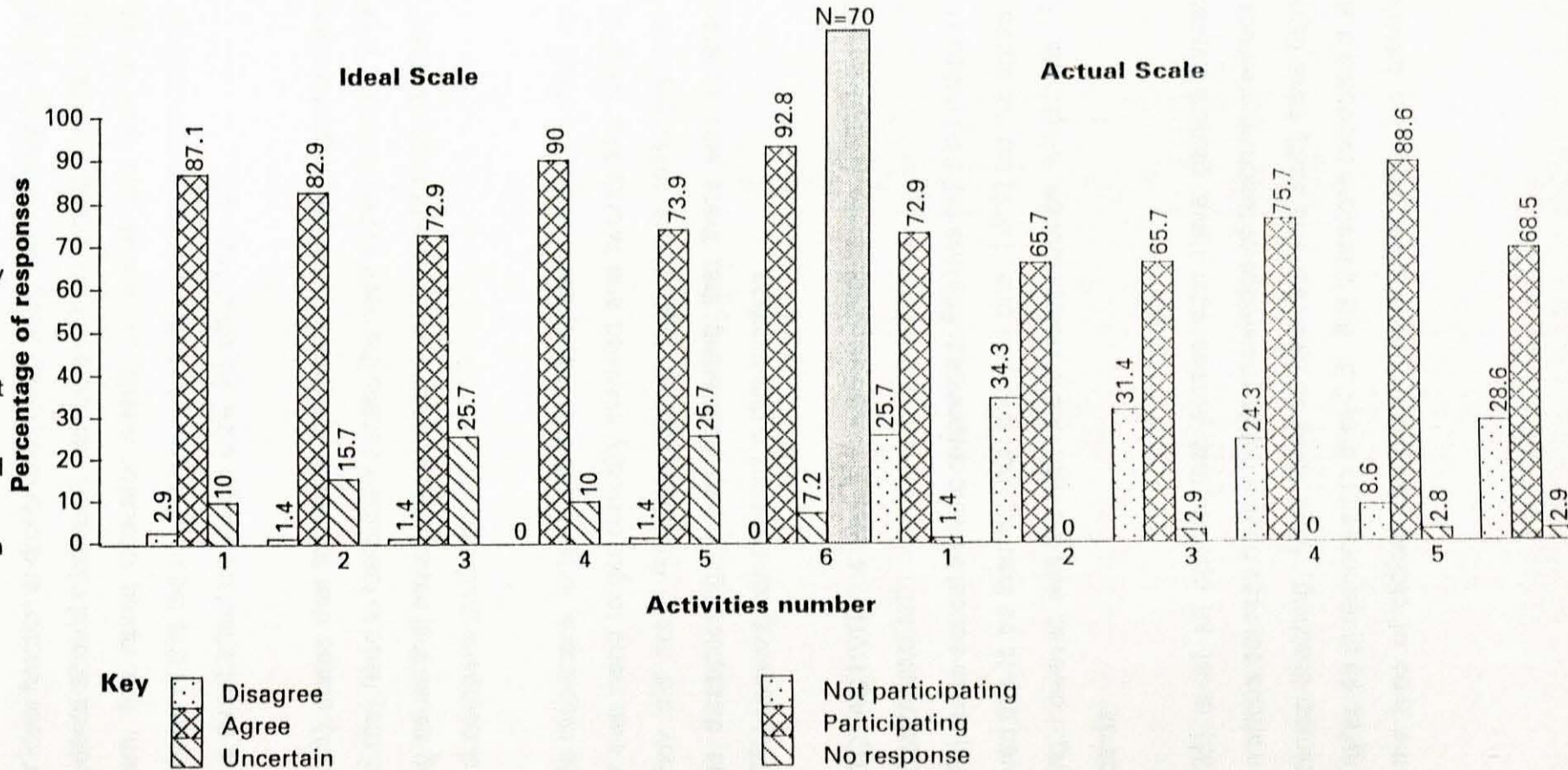


Figure 44: Responses of nurse educators to ideal and actual extent of participation in assessment for clinical instruction

RESPONSES TO ACTIVITY 4.10.1.2 : ASSESSING OWN NEED TO GET CLINICALLY INVOLVED

Responses in the ideal scale show that fifty eight (82,9%) respondents agreed that this was their ideal function and only one (1,4%) disagreed. Although clinical instruction of students should involve all members of the nursing, medical and paramedical team, the nurse educator needs to realise that she is an indispensable member of this team. Her role is to help students to learn clinical skills as this has a direct effect on patient care (Hinchliff 1986:35).

Mashaba (1994:51) states that for nurse educators to be well-organised for clinical instruction, they need to realistically assess the need to be involved. This means diagnosing issues that require one's personal involvement such as when, why and how to accompany students.

In the actual scale responses, forty six (65,7%) respondents indicated that they did assess their own need to get clinically involved and twenty four (34,3%) admitted that they did not. Although such a high score reflecting non-participation was disappointing, it was heartening that there was a large percentage (65,7%) showing commitment to this function.

RESPONSES TO ACTIVITY 4.10.1.3 : ASSESSING THE NATURE OF CLINICAL ACCOMPANIMENT

Of the seventy (70) nurse educators who responded, fifty one (72,9%) indicated that they perceived this to be their function and only one (1,4%) did not agree. A surprising finding, however, was the high rate of non-response, which was 18 (25,7%) respondents.

Hinchliff (1986:35) is of an opinion that nurses who have gained formal qualifications on various courses have a better knowledge of teaching methods to be used for clinical teaching. Most nurse educators in this study have high qualifications as reflected in responses to item 2.3. It is therefore expected that they assesses the type of clinical instruction that is given by other health

personnel as well as themselves.

In the actual scale, it shows that forty six (65,7%) respondents agreed that they were participating in assessing the nature of clinical accompaniment. The nurse educator is an important member of the clinical teaching team. Therefore, she has to determine whether other members of the team can interpret the clinical learning objectives and explore the best clinical teaching methods as these factors will influence the nature of accompaniment and consequently what a student learns.

RESPONSES TO ACTIVITY 4.10.1.4 : ASSESSING RELEVANCE OF CONTENT IN RELATION TO LEVEL

In the ideal scale, it appears that this item was perceived by nurse educators as their function as it was checked by sixty three (90%) respondents. No respondent rejected this statement although 7 (10%) did not respond to the item.

In the actual scale, fifty three (75,7%) respondents indicated that they were participating in assessing clinical learning content, and seventeen (24,3%) respondents said they were not. Although the score for actually practised role is lower than that in ideal scale by 14,3%, the above findings are still significant because the success of a student largely depends on whether the content relates to the clinical objectives drawn for the students' level. Failure to assess suitability of content could possibly result in student burnout and attrition.

RESPONSES TO ACTIVITY 4.10.1.5 : ASSESSING AVAILABILITY OF RESOURCES FOR CLINICAL INSTRUCTION

Scores in the ideal scale show that fifty one (72,9%) respondents said assessing availability of resources was the nurse educator's ideal function and only one (1,4%) respondent disagreed. When asked about actual participation, a surprisingly high positive response was obtained. Sixty two (88,6%) respondents stated that they actually participating in assessing availability of resources for clinical instruction. Only six (8,6%) said they do not do this function.

Adequate resources like enough staff and equipment, are essentials for a supportive clinical learning milieu. Lack of resources undermines the learning process. Reilly & Oermann (1985:102) suggest that nurse educators are expected to carry a major, but not the sole, responsibility for developing and maintaining a supportive learning environment.

RESPONSES TO ACTIVITY 4.10.1.6 : ASSESSING SUITABILITY OF PLACEMENT IN RELATION TO LEVEL

As depicted in Figure 4.5 (Ideal Scale), sixty five (92,8%) respondents acknowledged that this was the ideal function of nurse educators. No respondent disagreed with the statement. When asked whether they actually participated in placement of students according to level, forty eight (68,5%) respondents said they did and twenty (28,6%) indicated non-participation.

The nurse educator is the person who understands the curriculum and the theoretical background that students possess. It is therefore imperative that she participates in deciding where the students are placed in order to ensure that set clinical learning objectives are achieved. Hinchliff (1986:183) believes that even dates for the students' practical work must be set by college, even before the programme commences. She further states that the college is normally expected to indicate which syllabus areas are being met each term in order to link college work with practical work. This will ensure proper allocation according to expected proficiency level.

Scores elicited from the above responses show that actually practised roles yielded slightly lower percentages of positive responses when compared with scores from the ideal scale. This was a feature in all activities except in activity 4.10.1.5 (assessing availability of resources for clinical teaching). This is not a surprising finding, particularly when viewed against responses given in item 4.4 when nurse educators had to indicate reasons for non-participation in clinical instruction. Leading causes were low status accorded to clinical instruction and the fact that it does not give any academic credits. This could account for the

"non-participation" rate that was as high as 34,3% for activity 4.10.1.2 (assessing the need to get clinically involved).

It is therefore not surprising that activities which are considered non-beneficial academically are not well practised even though they are perceived as ideal functions of nursing education. It can, then be deduced that nurse educators do not adequately practise assessment activities that they perceive as their ideal functions.

4.3.14 ITEM 4.10.2 IDEAL AND ACTUAL EXTENT OF PARTICIPATION IN PLANNING FOR CLINICAL INSTRUCTION BY NURSE EDUCATORS

Van Hoozer et al (1987:73,185) state that careful planning is requisite to carrying out quality instruction. They further state that effective planning should show articulation between curriculum and clinical learning experiences. The nurse educator is, therefore, professionally obliged to participate in planning of instruction activities as she is the person who understands the curriculum and can translate it to clinical learning objectives. According to Infante (1985:31), planning is essential because most students cannot translate objectives into the context of clinical activities on their own.

Table 4.15 and Figure 4.5 present responses to Item 4.10.2.

RESPONSES TO ACTIVITY 4.10.2.1 : PLANNING CLINICAL TIME TABLES

This activity was checked by fifty six (80%) respondents as an ideal function of nurse educators, while five (7,1%) disagreed with the statement. Nine (12,9%) did not respond to this item. In the actual scale, only thirty five (50%) respondents indicated that they participate in planning of clinical time tables. Thirty (42,9%) respondents however, stated that they were not participating in this function.

TABLE 4.15 PERCENTAGE DISTRIBUTION OF RESPONSES TO EXTENT OF IDEAL AND ACTUAL PARTICIPATION OF NURSE EDUCATORS IN PLANNING FOR CLINICAL INSTRUCTION N = 70

ACTIVITIES	IDEAL SCALE						ACTUAL SCALE					
	SD	D	U	A	SA	NR	1	2	3	4	5	NR
1. Clinical Time Tables	3 4,3%	2 2,92%	4 5,7%	36 51,4%	20 28,5%	5 17,1%	18 25,7%	12 17,1%	19 27,1%	14 20%	2 2,9%	5 7,1%
2. Clinical Learning Programme	0 0%	0 0%	5 7,1%	41 58,6%	23 32,9%	1 1,4%	11 15,7%	16 22,9%	22 31,4%	14 20%	4 5,7%	3 4,3%
3. Best strategies for clinical instruction	2 2,9%	3 4,3%	7 10%	37 52,9%	16 22,8%	5 17,1%	11 15,7%	18 25,7%	20 28,5%	18 25,7%	2 2,9%	1 1,4%
4. Designing/revising clinical workbooks	1 1,4%	3 4,3%	4 5,7%	33 47,1%	29 41,4%	0 0%	13 18,5%	13 18,5%	28 40%	10 14,3%	6 8,5%	0 0%
5. Appropriate times for accompaniment	2 2,9%	2 2,9%	7 10%	36 51,4%	23 32,9%	0 0%	11 15,7%	13 18,5%	22 31,4%	18 25,7%	6 8,5%	0 0%

KEY:

IDEAL SCALE

SD = Strongly Disagree

D = Disagree

U = Uncertain

A = Agree

SA = Strongly Agree

ACTUAL SCALE

1 = Not at all

2 = Minimally

3 = Reasonably

4 = Considerably

5 = Great Deal

NR = No response

Activities:

1. Planning clinical time tables.
2. Planning clinical learning programme.
3. Planning best strategies for clinical instruction.
4. Designing/revising clinical workbooks.
5. Planning appropriate times for clinical instruction.

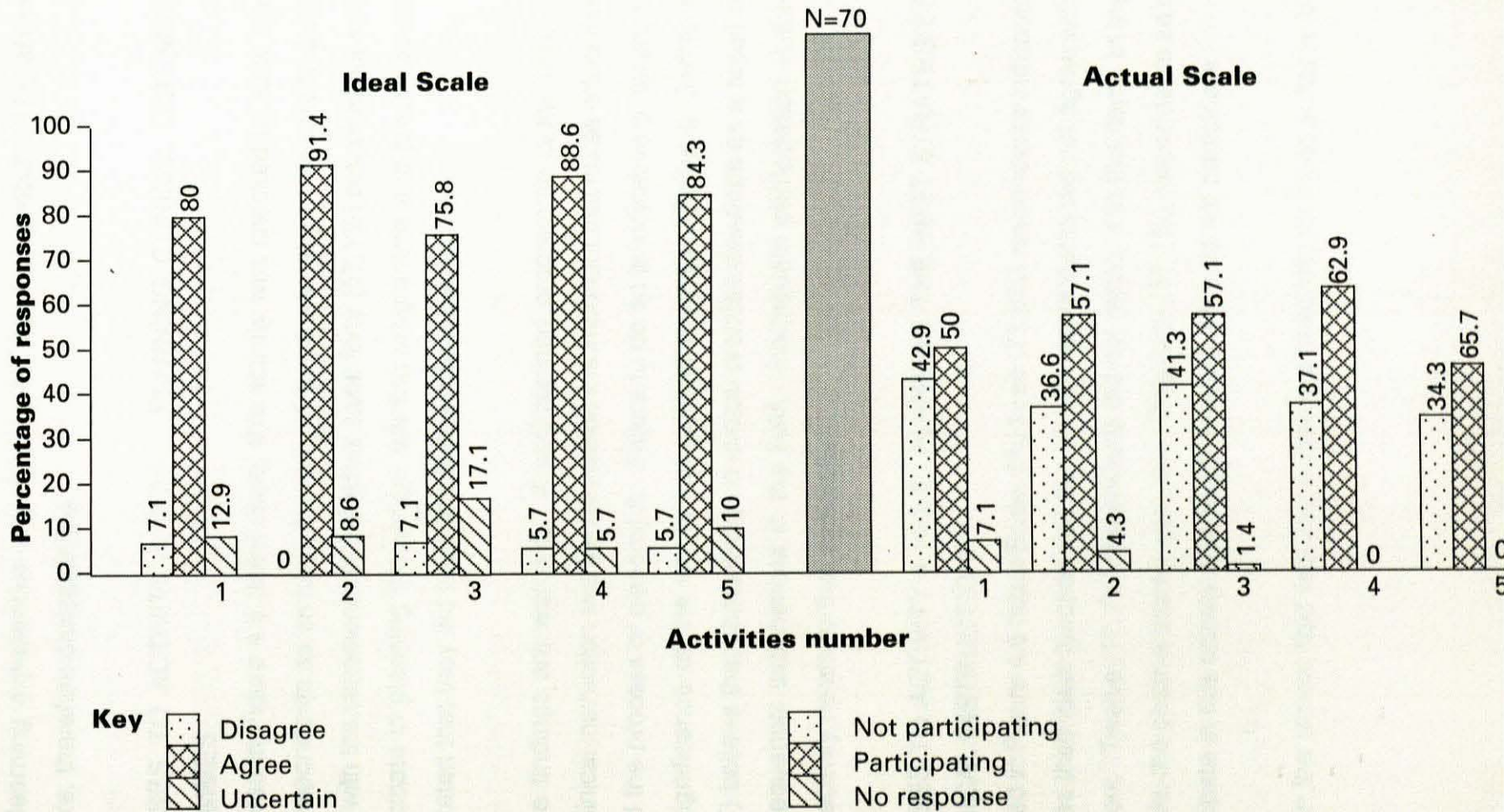


Figure 4.5: Responses of nurse educators to ideal and actual extent of participation in planning for clinical instruction

Time tables are important for providing information to the clinical instruction-learning participants about times of learning sessions, duration, venues, attendants and teachers. Although Quinn (1980:267) states that this is a matter of administration nurse educators should participate therein to ensure that practical learning experiences are on par with the theory input. The above findings are, therefore disappointing.

RESPONSES TO ACTIVITY 4.10.2.2. : PLANNING CLINICAL LEARNING PROGRAMMES

As illustrated in Figure 4.6 (Ideal scale) this activity was checked by sixty four (91,4%) respondents as an ideal function of nurse educators. No respondents disagreed with the statement. In the actual scale forty (57,1%) respondents said they participate in planning the clinical learning programme and twenty seven (38,6%) stated that they did not participate in this activity.

The above findings are worrying. A well-planned programme is the core of effective clinical instruction and for this reason it is important that nurse educators spearhead the process of planning it. Failure to do so is indicative of failure to see the significance of the whole instructional process. Reilly & Oermann (1985:247) believe that competency in clinical practise develops as a result of planned sequential experiences in the field. Inadequate participation in this important activity needs further exploration.

RESPONSES TO ACTIVITY 4.10.2.3 : PLANNING THE BEST STRATEGIES FOR CLINICAL INSTRUCTION

As illustrated in Figure 4.6 (Ideal Scale) fifty three (75,6%) respondents indicated that this was their ideal function and five (7,1%) respondents did not agree with the statement. Twelve (17,1%) respondents did not respond to this item. In the Actual Scale, the positive scores were low. Only forty (57,1%) respondents said they participate in this activity and twenty nine (41,4%) did not participate.

Teaching in the clinical field requires a variety of teaching methods suitable for

achievement of the set clinical objectives and the desired competencies. According to Reilly & Oermann (1985:105,106) planning for clinical practice experience includes the decision regarding methods to be used for achievement of objectives. They further point out that it is the teacher who should choose the methods of instruction depending on objectives, students' needs, ability to cope as well as her own teaching ability. It is, therefore, worrying that nurse educators can distance themselves from such a crucial task.

RESPONSES TO ACTIVITY 4.10.2.4. : DESIGNING /REVISING CLINICAL WORKBOOKS

A workbook is a significant document in nurse education and training. It is issued to each student when a programme or level is begun. The student is expected to have an individual worksheet filled up after completion of a certain nursing skill that was done under supervision. A workbook has to be designed by a team that includes a nurse educator and has to be revised when certain skills have to be modified or added. Hinchliff (1986:78) states that a workbook is meant to give guidelines for learning.

TEACHING

In the ideal scale, this activity yielded favourable responses. Of the seventy respondents sixty two (88,6%) agreed that this was their ideal function and only four (5,7%) said it was not. In the actual scale, forty four (62,9%) respondents reported that they participate in this activity and twenty four (34,4%) said they did not participate.

LEARNING

Cristy (1980) as cited by Reilly & Oermann (1985:12) states that clinical practice has always been a function of nursing education. The nurse educator, therefore, needs to make time to visit clinical area. This must be planned according to her workload and student needs. If clinical instruction is a facilitative process towards student learning, then it is proper that nurse educators take some time off their theory-oriented environment in order to help students to find meaning in their clinical work.

From the above findings, it is apparent that planning for clinical instruction is yet another area that does not enjoy much of the nurse educator's attention. Scores reflecting non-participation were disappointingly high, ranging from 34,3% to 42,9%. It is worrying to observe that nurse educators perceive planning for clinical instruction as their ideal function and yet fail to fulfil it. This item has shown a great deal of incongruency between the ideal and actually practised roles of nurse educators.

4.3.15 ITEM 4.10.3 IDEAL AND ACTUAL EXTENT OF PARTICIPATION IN IMPLEMENTATION OF CLINICAL INSTRUCTION BY NURSE EDUCATION

Implementation means carrying out a drawn plan with regard to clinical teaching. It means the actual instruction of students by a nurse educator. To be able to do this effectively, the nurse educator herself, has to have adequate clinical skills that she will impart to students. Responses to this item are presented in Table 4.16 and Figure 4.6.

RESPONSES TO ACTIVITY 4.10.3.1 : COMPILING MATERIAL FOR CLINICAL TEACHING

Scores in the ideal scale show that the above activity was checked by fifty eight (82,8%) respondents as their ideal function and six (8,6%) respondents disagreed. In the actual scale, fifty four (72,1%) respondents said they participate in this function while sixteen (22,9%) said they do not. This finding almost compares with the response in the ideal scale, which is quite pleasing. Learning a clinical skill can be very difficult to the student even after repeated demonstrations. To help the students to master the required clinical skills, multimedia such as films, filmstrips and videos should be made available to beginners and slow learners so that they view these at their own pace (Smith 1977:154). Compiling such learning material should be done by the nurse educator to augment student learning.

TABLE 4.16 RESPONSES OF NURSE EDUCATORS TO THE IDEAL AND ACTUAL EXTENT OF PARTICIPATION IN IMPLEMENTATION OF CLINICAL INSTRUCTION N = 70

ACTIVITIES	IDEAL SCALE						ACTUAL SCALE					
	SD	D	U	A	SA	NR	1	2	3	4	5	NR
1. Compiling learning material for clinical instruction.	2 2,9%	4 5,7%	6 8,6%	29 41,4%	29 41,4%	0 0%	6 8,6%	10 14,3%	27 38,6%	20 28,6%	7 10%	0 0%
2. Conducting clinical learning session	0 0%	10 14,3%	2 2,9%	27 38,6%	29 41,4%	2 2,9%	0 0%	8 11,4%	27 38,6%	22 31,4%	13 18,6%	0 0%
3. Accompany students in clinical area	1 1,4%	8 11,4%	0 0%	33 47,1%	28 40%	0 0%	2 2,9%	8 11,4%	28 40%	22 31,4%	10 14,3%	0 0%
4. Role modelling for students	0 0%	7 10%	4 5,7%	30 51,4%	29 47,1%	0 0%	0 0%	15 21,4%	30 42,9%	14 20%	11 15,7%	0 0%
5. Using colleagues to complement clinical instruction	0 0%	2 2,9%	12 17,1%	30 42,9%	26 37,1%	0 0%	3 4,3%	17 24,3%	19 27,1%	19 27,1%	12 17,1%	0 0%
6.												

KEY:

IDEAL SCALE

SD = Strongly Disagree

D = Disagree

U = Uncertain

A = Agree

SA = Strongly Agree

NR = No response

ACTUAL SCALE

1 = Not at all

2 = Minimally

3 = Reasonably

4 = Considerably

5 = Great Deal

RESPONSES TO ACTIVITY 4.10.3.2 : CONDUCTING CLINICAL LEARNING SESSIONS

Of the seventy nurse educators who responded to this activity, fifty six (80%) stated that this was their ideal function, while ten (14,3%) responded negatively. Four (5,7%) were uncertain. In the Actual Scale, responses show that sixty two (88,6%) respondents said they participate in conducting clinical instruction and eight (11,4%) stated that they do not conduct any clinical learning sessions.

These results are an indication that nurse educators realise the importance of showing students how to do it since this activity yielded the highest actual score. These findings tally with the assertion that nurse educators are not permanent clinical staff, but they are expected to spend some time with students in order to assist them with nursing skills they need to acquire (Quinn 1980:398). To support this, Reilly & Oermann (1985:108) believe that learning results from experiential teaching which ensures interaction with clients and participation in the events of the clinical field. Nurse educators need to conduct demonstrations, clinical nursing conference and case presentations in order to impart clinical skills.

RESPONSES TO ACTIVITY 4.10.3.3 : ACCOMPANYING STUDENTS IN THE CLINICAL AREA

In the Ideal Scale, this activity yielded the highest scores. Of the seventy nurse educators who responded to this item, sixty one (87,1%) indicated that they perceived this activity as their function and only nine (12,9%) disagreed with the statement. The actual scale responses show that sixty (85,7%) respondents indicated that they accompany students in clinical area and ten (14,3%) were not participating in this function.

Accompaniment of students is the duty of a nurse educator, who has to guide and support the student in the threatening clinical environment. There is a need, therefore, that learners should work closely with nurse educators while carrying out nursing skills. Hinchliff (1986:52) suggests that learning requires continuity

from theory to practice. This can be facilitated by the presence of a nurse educators in the clinical area.

RESPONSES TO ACTIVITY 4.10.3.4 : ROLE MODELLING FOR STUDENTS

Role modelling means that a nurse educator has to demonstrate desired behaviours and values that need to be taught to students. Infante (1985:145) states that role models teach by action. A nurse educator, therefore, needs to be professionally mature before she can role model for others. According to Van Hoozer et al (1987:200), role modelling is an important means of promoting professional socialisation and competence in student nurses. The nurse educator needs to exhibit a variety of skills during her interaction with clients and it is these professional behaviours that need to be emulated by students. From the responses to Items 1.2 (age group) and 2.3 (nurse educators' highest qualifications), they should be mature enough to role model effectively. When asked whether role model for students was their ideal function, fifty nine (84,3%) respondents agreed and seven (10%) disagreed. Four (5,7%) respondents were not sure.

Nurse educators who agreed that they actually role modelled for students were in the clinical area were fifty five (78,6%) and fifteen (21,4%) said they do not role model for students. It could not be established, however, what nurse educators understood by role modelling.

RESPONSES TO ACTIVITY 4.10.3.5 : USING COLLEAGUES TO COMPLEMENT CLINICAL INSTRUCTION

As shown in Figure 4.7 (Ideal Scale), fifty six (80%) nurse educators agreed that ideally they had to use colleagues while two (2,9%) disagreed with the statement. The scores on the actual scale reveal that fifty (71,6%) respondents said they participate in this function and twenty (28,6%) said they do not.

Quinn (1980:399) acknowledges that clinical teaching requires a high degree of commitment, but in the same breath, she admits that nurse educators have other

duties in the school of nursing. It is for this reason, therefore, that healthy relations between nurse educators and ward staff must be nurtured so that they complement each other for the benefit of the student. This is confirmed by Mhlongo (1994:81), who maintains that when ward sisters, tutors and clinical instructors work together, they gain deeper insight into each other's role.

Implementation appears to be the one phase of the instructional process so far, in which actual participation of nurse educators is almost on par with their perceptions. The highest positive score was 88,6% for conducting clinical learning sessions followed by 85,7% for accompanying students in the clinical area. These scores are above those in the Ideal scale where 87,1% was the highest (conducting clinical learning sessions) followed by 84,3% for role modelling for students. This was a heartening finding.

4.3.16 ITEM 4.10.4 IDEAL AND ACTUAL EXTENT OF PARTICIPATION BY NURSE EDUCATORS IN EVALUATION OF CLINICAL INSTRUCTION

Before a nurse becomes a fully fledged professional, her clinical competence must be evaluated. The purpose of evaluation is to establish whether the student nurse has mastered the fundamental principles for performance of nursing skills. This has to be done throughout a nurse's period of education and training. The role of a nurse educator is to undertake this task and share it with other professional nurses. Smith (1977:221) suggests that the teacher should make it known that she is responsible for evaluating students' clinical work. The importance of evaluation is further emphasised by Infante (1985:149) who states that nursing is a health service-oriented profession and evaluation is important to preserve the safety of the public to be served by the new practitioner.

In this item nurse educators were to indicate the extent to which they agreed that the activities listed in Table 4.17 were perceived by them as their ideal function and the extent to which they practised them.

TABLE 4.17 RESPONSES OF NURSE EDUCATORS TO IDEAL AND ACTUAL EXTENT OF PARTICIPATION IN
EVALUATION FOR CLINICAL INSTRUCTION N = 70

ACTIVITIES	IDEAL SCALE						ACTUAL SCALE					
	SD	D	U	A	SA	NR	1	2	3	4	5	NR
1. Designing evaluation tools	0 0%	3 3,43%	1 1,4%	32 45,7%	29 41,4%	5 7,1%	1 1,4%	10 14,3%	22 31,4%	22 31,4%	10 14,3%	5 7,1%
2. Setting clinical evaluation time tables	1 1,4%	8 11,4%	2 2,9%	29 41,4%	29 41,4%	1 1,4%	11 15,7%	9 12,9%	17 24,3%	25 35,7%	8 11,4%	0 0%
3. Conducting clinical evaluation	0 0%	7 10%	1 1,4%	28 40%	34 48,6%	0 0%	5 7,1%	5 7,1%	20 28,6%	24 34,3%	14 20%	2 2,9%
4. Moderating clinical evaluation results	2 2,9%	3 4,3%	11 15,7%	29 41,4%	28 40%	2 2,9%	29 41,4%	8 11,4%	12 17,1%	7 10%	11 15,7%	3 4,3%
5. Serving in clinical evaluation results	5 7,1%	3 4,3%	3 4,3%	29 41,4%	28 40%	2 2,9%	15 21,4%	24 32,3%	14 20%	9 12,9%	6 8,6%	2 2,9%
6. Seeking feedback from students	0 0%	4 5,7%	9 12,9%	25 35,7%	31 44,1%	1 1,4%	14 20%	11 15,7%	22 31,4%	15 21,4%	8 11,4%	0 0%

KEY:

IDEAL SCALE: SD = Strongly Disagree
D = Disagree
U = Uncertain
A = Agree
SA = Strongly Agree

ACTUAL SCALE: 1 = Not at all
2 = Minimally
3 = Reasonably
4 = Considerably
5 = Great Deal

NR = No response

Activities:

1. Designing evaluation tools.
2. Setting clinical evaluation time tables.
3. Conducting clinical evaluation.
4. Moderating clinical evaluation results.
5. Serving in clinical evaluation committee.
6. Seeking feedback from students about value of clinical instruction.

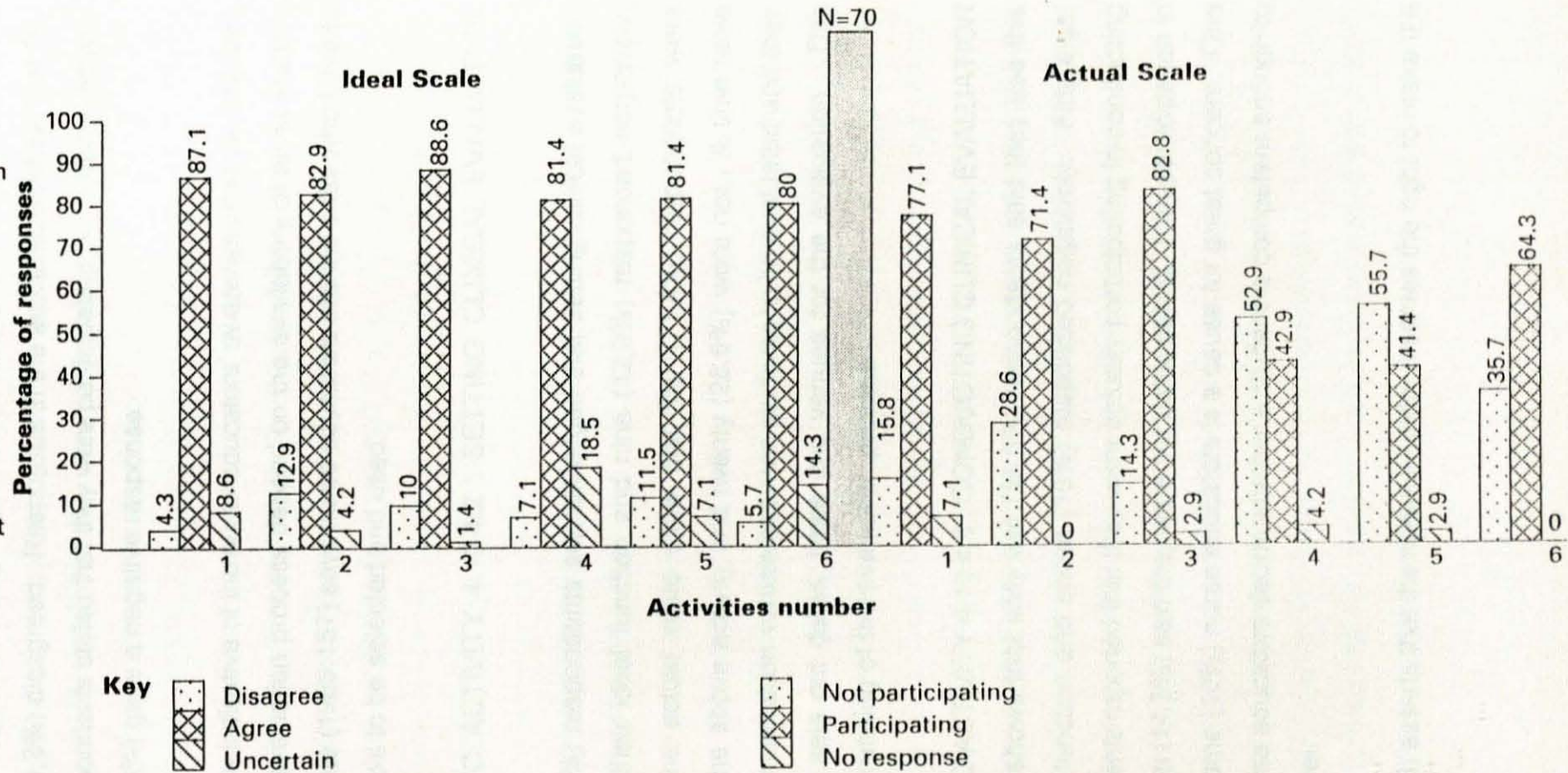


Figure 4.7: Responses of nurse educators to ideal and actual extent of participation in evaluation for clinical instruction

RESPONSES TO ACTIVITY 4.10.4.1 : DESIGNING EVALUATION TOOL

Of the seventy nurse educators who responded to this statement, sixty one (87,1%) acknowledged that designing evaluation tools was their ideal function and only three (4,3%) disagreed. Responses in the actual scale show that fifty four (71,4%) respondents stated that they were participating in the above activity and eleven (15,8%) gave a negative response.

These findings are indicative of the nurse educators' awareness that the hallmark of a successful evaluation process depend on the availability of an evaluation instrument. Infante (1985:157) says nurse educators are the ones who have to decide on the tools to be selected and used.

RESPONSES TO ACTIVITY 4.10.4.2 : SETTING CLINICAL EVALUATION TIMETABLES

Fifty eight (82,9%) respondents acknowledged that setting clinical evaluation timetables was their ideal function and nine (12,9%) responded negatively. Responses in the actual scale show that fifty (71,4%) respondents were participating in the above activity and twenty (28,6%) were not. A time table serves as a communication vehicle between students to be evaluated and their examiners as it sets out dates, times and venues for the evaluation. This ensures smooth running of the evaluation process.

RESPONSES TO ACTIVITY 4.10.4.3 : CONDUCTING CLINICAL EVALUATION

The Ideal scale shows that sixty two (88,6%) respondents said they see this activity as their function and seven (10%) responded negatively. Fifty eight (82,8%) respondents reported that they were actually participating in conducting evaluation, but ten (14,3%) said they were not participating. Non-participation in this activity by some (10%) nurse educators is a cause for great concern. One wonders how nurse educators decide whether a student is competent enough to start the next level.

Infante (1985:156) asserts that the nurse educator reserves the right to make the

final judgement about the students' performance. This indicates that nurse educators cannot distance themselves from such an important function. It is worrying that some nurse educators do not participate because this suggests how unaware they are of the importance of ultimately measuring the effectiveness and the worth of the instructional exercise.

RESPONSES TO ACTIVITY 4.10.4.4 : MODERATING CLINICAL EVALUATION RESULTS

Nurse educators that perceived moderating clinical evaluation results ideal function were fifty seven (81,4%) and five (7,1%) respondents said this was not their function. Scores in the actual scale were disappointingly low. Only thirty (42,9%) respondents said they participate in this activity while thirty seven (52,9%) stated that they were not participating.

These results make one to wonder why so many nurse educators were not participating in this function. Further pursuance could probably elicit more information on reasons for such poor responses.

RESPONSES TO ACTIVITY 4.10.4.5 : SERVING IN CLINICAL EVALUATION COMMITTEE

Of the seventy respondents, fifty seven (81,4%) reported that this was ideally the function of nurse educators as shown in Figure 4.7. Eight (11,5%) disagreed with the statement and five (7,1%) were uncertain. Serving in clinical evaluation committees enables nurse educators to reflect on students' performance as indicated by evaluation outcomes. They also share concerns and compare student competencies in order to make objective judgement that should lead to solution for identified learning needs.

RESPONSES TO ACTIVITY 4.10.4.6 : SEEKING FEEDBACK FROM STUDENTS ABOUT VALUE OF CLINICAL INSTRUCTION

The Ideal Scale shows that fifty six (80%) respondents agreed that seeking feedback from students about the value of clinical instruction was ideally their

function and only four (5,7%) disagreed. In response to actual participation in the above activity, forty five (64,3%) respondents said they were participating, while twenty five (35,7%) said they were not.

Feedback from students should be encouraged since it will make nurse educators to be aware of problems or gaps that exist in instruction and evaluation process. Students need to be aware that nurse educators are not infallible and do not necessarily know everything. This will make students to be at ease with their educators. Smith (1977:43) suggests that this helps students to avoid unrealistic expectations that once they graduate, they will or should know everything.

From the responses to Item 4.10.4, it is observed that some activities in evaluation are not adequately practised by nurse educators despite the fact that they perceive them as theirs. It is observed with concern that in some activities like moderating clinical evaluation results and serving in clinical evaluation committees, non-participating scores were higher (52,9%) and (55,7%) respectively, than scores reflecting participation.

4.3.17 ITEM 4.10.5 IDEAL AND ACTUAL EXTENT OF PARTICIPATION IN RECORD KEEPING RELATED TO CLINICAL INSTRUCTION BY NURSE EDUCATORS
Evaluation of the student's clinical performance is a process. It has to start at the beginning of a programme until completion of the course. To be able to provide feedback on progress and to determine whether objectives have been met, accurate records have to be kept about each student. Nurse educators also need to keep records of their own clinical activities.

RESPONSES TO ACTIVITY 4.10.5.1 : KEEPING AN ACCURATE CLINICAL PROFILE ON EACH STUDENT

Of the seventy respondents, fifty seven (81,4%) agreed that the above activity was ideally a nurse educator's function while 8 (11,4%) did not agree with the statement. Five (7,2%) did not respond to the item.

TABLE 4.18 RESPONSES OF NURSE EDUCATORS TO EXTENT OF IDEAL AND ACTUAL PARTICIPATION IN RECORD-KEEPING FOR CLINICAL INSTRUCTION N = 70

ACTIVITIES	IDEAL SCALE						ACTUAL SCALE					
	SD	D	U	A	SA	NR	1	2	3	4	5	NR
1. Keeping of accurate clinical profile of student	5 7,1%	3 4,3%	3 4,3%	23 32.9%	34 48,6%	5 7,1%	6 8,6%	13 18,6%	16 22,6%	20 28,6%	13 18,6%	2 2,9%
2. Keeping record of own activities	2 2,9%	4 5,7%	3 4,3%	3 4,3%	25 35,7%	5 7,1%	11 15,7%	10 14,3%	26 37,1%	10 14,3%	9 12,6%	4 5,7%

KEY:

IDEAL SCALE

SD = Strongly Disagree

D = Disagree

U = Uncertain

A = Agree

SA = Strongly Agree

NR = No response

ACTUAL SCALE

1 = Not at all

2 = Minimally

3 = Reasonably

4 = Considerably

5 = Great Deal

Figure 4.18: Responses of nurse educators to ideal and actual extent of participation in record keeping for clinical instruction

Activities:

1. Keeping accurate clinical profile of students.
2. Keeping records of own clinical activities.

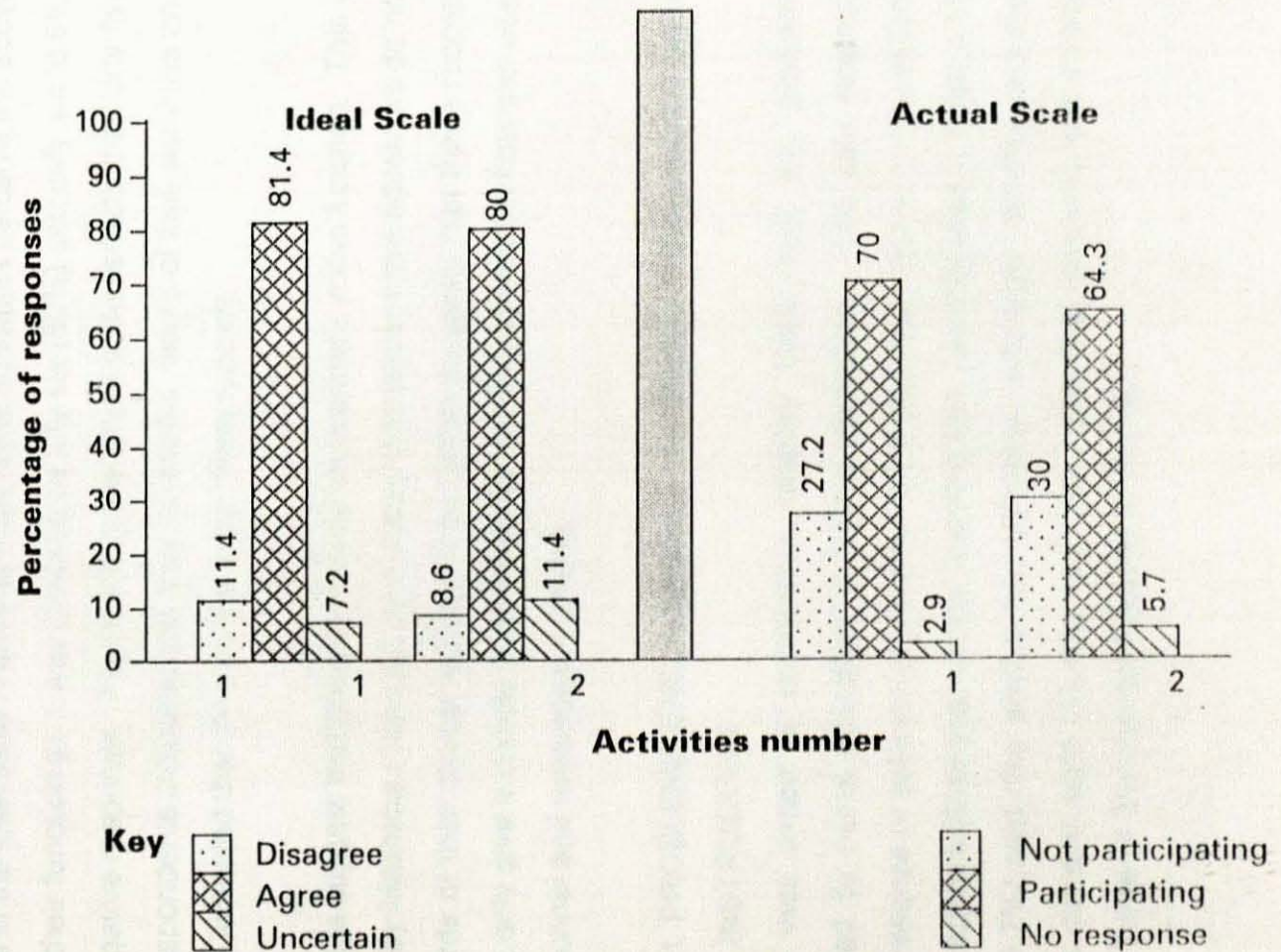


Figure 4.8: Responses of nurse educators to ideal and actual extent of participation in record keeping for clinical instruction

Responses given in actual scale reflect that forty nine (70%) respondents stated that they actually kept accurate student records and nineteen (27,1%) said they did not keep records. Record keeping does not help only with monitoring of the student's progress but it assists nurse educators when an exit in identifying strengths and weaknesses of the individual student. This will ensure that remedial teaching is done where necessary.

RESPONSES TO ITEM 4.10.5.2 : KEEPING A RECORD OF OWN CLINICAL ACTIVITIES

Responses in the ideal scale show that most nurse educators perceive the above activity as their function as it was checked by fifty six (80%) and only six (8,6%) gave a negative response. Figure 4.8 in the actual scale reflects that forty five (64,3%) respondents indicated that they do keep a record of their activities and two (2,9%) indicated that they do not keep these records.

Such findings suggest that there is minimal involvement in this function. This is confirmed by Mashaba (1994:52) who states that some nurse educators do not keep records of their clinical activity. She further suggests that these records should not only give a clinical time schedule, but should indicate how she uses other personnel and resources in clinical.

4.3.18 ITEM 4.11 PROBLEMS ENCOUNTERED BY NURSE EDUCATORS WITH CLINICAL INSTRUCTION

This item was aimed at establishing whether there were any problems encountered by nurse educators in clinical instruction. This was essential because presence or absence of problems could be a major factor in determining how nurse tutors fulfilled their clinical teaching role. As indicated in Table 4.19, eleven (15,7%) said they always had problems, forty eight (68,6%) said they sometimes did and eight (11,4%) said they never had problems with clinical teaching. Three (4,3%) did not respond to this item.

TABLE 4.19 PERCENTAGE DISTRIBUTION OF RESPONSES TO
EXISTENCE OF PROBLEMS ENCOUNTERED BY NURSE
EDUCATORS WITH CLINICAL TEACHING N = 70

RESPONSES	FREQUENCIES	PERCENTAGE
Always	11	15,7
Sometimes	48	68,6
Never	8	11,4
No response	3	4,3
TOTAL	70	100

A function as complex and as demanding as clinical teaching cannot be without problems. It is therefore not surprising that a large percentage (68,6%) of respondents said they do experience problems. Van Hoozer et al (1987:175) support these findings when stating that research done over decades has uncovered a lot of unsolved problems related to clinical teaching.

4.3.19 ITEM 4.12 NATURE OF PROBLEMS ENCOUNTERED BY NURSE EDUCATORS IN CLINICAL TEACHING

Nurse educators were further asked to identify these problems and give possible solutions thereto. Numerous problems were pointed out and the ones checked more often than others are reflected below in Table 4.22.

TABLE 4.20 PERCENTAGE DISTRIBUTION OF PROBLEMS ENCOUNTERED
BY NURSE EDUCATORS WITH CLINICAL INSTRUCTION

PROBLEMS	FREQUENCY	PERCENTAGE
Lack of facilities	14	20
Overcrowded wards	8	11,4
Lack of space for demonstrations	7	10
Staff shortage	7	10
Student absenteeism	6	8,6

N.B. The scores in the above Table will not add up to 70 or 100% because an item was checked by more than one respondent.

Problems identified by respondents included lack of facilities 14 (20%), overcrowded wards 8 (11,4%), lack of adequate space for demonstration and staff shortage were checked by 7 (10%) respondents and 6 (8,6%) complained of student absenteeism. They reported that student nurses ran away from patient care situations. Another 5 (7,1%) reported that students were used as workforce and this made it difficult to teach since ward sisters expected that they should not be taken away from work.

It seems however that problems with clinical teaching do not only affect nurse educators. In a study conducted by Mhlongo (1994:105) on the nursing science perspective on the role of the unit sister in teaching student nurses in KwaZulu Hospitals, some of the above-mentioned problems surfaced like lack of resources and staff shortage.

Other problems that nurse educators identified included the following:-

- * distance between the campus and the students' practice area
- * rigid ward programmes that did not favour student accompaniment
- * negative attitude from some ward staff who treat nurse tutors as strangers
- * no time slots in timetable for clinical instruction
- * staff indifference to student learning
- * despondence of dedicated nurses
- * wards too busy and student available only for ward routine
- * unmanageable academic workload
- * lack of respect by students

The above-named problems have also been identified by Schuveer & Gebbie (1990) and (1915) as cited in van Hoozer et al (1987:175). They cite the following:-

- students being used to meet staffing needs, not their learning needs

- student's learning one thing in classroom and doing another in the hospital.

Nurse educators were further requested to suggest possible solutions to the problems and the following were given:-

- * Students were not to be used as workforce. Service had to employ other categories of nurses so that student learning was made a priority.
- * Supernumerary student status to relieve them of routine ward functions
- * In-service education for ward sisters to rekindle the culture of involvement in student teaching
- * More stringent measures to control students while in the clinical area
- * Clinical laboratory on campus for when a lecturer cannot go to the actual bedside situation. This would counter the problem of distance between campus and practice area.
- * Management to motivate for more ward staff, equipment and more clinical instructors and
- * Establishment of healthy relations between nursing education and service

4.4 CONCLUSION

Chapter 4 dealt with analysis, presentation, interpretation and discussion of the research findings. Analysis of data revealed that on the whole nurse-educators perceive clinical instruction activities as their ideal function, but that they do not adequately participate in carrying them out. Several factors were given as problems encountered in clinical area. It is not quite clear whether these are deterrents from fulfilling this function or poor participation is due to unwillingness and the fact that clinical instruction is rated low in the nurse educators' priority list of activities.

CHAPTER 5

REPORT ON FINDINGS, CONCLUSIONS, LIMITATIONS, IMPLICATIONS OF THE STUDY AND RECOMMENDATIONS**5.1 INTRODUCTION**

This chapter focuses on the presentation of a brief overview of the project. Areas of major emphasis will be summary of findings, conclusions, implications of the findings, limitations, recommendations and suggestions for further research.

5.2 SUMMARY OF THE STUDY

To increase clarity of content of this report, it is desirable that a brief revisit be done to the problem statement, objectives of the study, reviewed literature and methodology used to collect data.

5.2.1 STATEMENT OF THE PROBLEM

The problem in this study was an apparent lack of sufficient participation in clinical instruction by nurses educators.

5.2.2 OBJECTIVES OF THE STUDY

This study aimed at attaining the following objectives:-

- * To determine the nurse educators' perception of their role in clinical instruction
- * To determine the nature and frequency of clinical accompaniment i.e. extent to which nurse educators participate in clinical instruction.
- * To establish the extent to which nurse educators actually practise activities that they perceive as their ideal functions.
- * To identify reasons or causes of insufficient or non-participation of nurse educators in clinical instruction.
- * To identify problems encountered by nurse educators with clinical instruction and solutions thereto.

5.2.3 REVIEWED LITERATURE

Nursing education is the backbone of nursing practice and the ultimate goal of nursing practice is good quality patient care (Mashaba 1985:32). Reviewed literature revealed that the role of nurse educators in clinical instruction is a contentious issue. A study conducted by Clifford (1994:272) on the role of the nurse educator showed that most nurse educators were not certain of their clinical teaching responsibilities. In another study by Fawcett & McQueen (1994:264-271) on the role of the nurse educator, most nurse teachers considered clinical instruction as important for student learning, but they stated that they should not be expected to do it. This indicates that some nurse educators do not perceive clinical teaching as their function.

The view that some nurse educators do not perceive clinical teaching as their ideal function is not shared by all nurse educators. Steele (1991) as cited by Broussard et al (1996:85) did a study on the role and role strain experienced by nurse educators. Their response revealed that they identified themselves as nurses who teach both theory and clinical skills. This shows that nurse tutors are aware of their teaching role in the clinical area. To confirm this, Mashaba (1994:46,47) states that some nurse educators find it even unnecessary to deliberate on this since application of theory to practice is implicit in the nurse educator's function.

It also came to light through reviewed literature that the nature of the nurse teacher's clinical activities and duration of clinical visits was still very obscure. While some indicated that they spend a minimum time of one to two hours, others gave seven hours or more per week (Clifford 1996:604-605). Activities that were identified as actually performed by nurse educators included counselling students, contact with colleagues (Lee 1996:1128). She further noted that clinical activities.

These findings are on par with the results of a study on the role of nurse teachers in Norway by Crotty (1992:33-36). Findings from this study revealed that nurse

teachers saw teaching and supervision of student in the clinical area as the function of ward practitioners. They further emphasised that theirs was teaching in the college and liaison with and supporting ward practitioners.

Reasons given for poor and non-participation in clinical instruction included:-

- multi-dimensional role of nurse teachers resulting in role overload and role strain
- lack of clinical credibility emanating from lack of adequate clinical skills
- lack of formal training and education for clinical instruction during role taking and
- negative attitude towards clinical teaching

5.2.4 METHODOLOGY

5.2.4.1 RESEARCH DESIGN

The research approach used was a cross-sectional descriptive survey. It was chosen for its appropriateness to elicit information on views and perceptions of nurse educators about their role in clinical teaching.

5.2.4.2 RESEARCH INSTRUMENT

Since the questionnaire was thought to be more convenient for objectivity and reaching distant participants, it was chosen for this survey. The questionnaire items were designed according to the objectives of this study, supported by reviewed literature from previous studies that were related to clinical teaching and the role of nurse educators therein.

The questionnaire consisted of open-ended and close-ended questions. It also had a double-barrell Likert scale. One dimension of the scale (ideal) was intended to elicit information on the extent to which nurse educators perceived the given activities as their clinical teaching functions. The other dimension (actual) required respondents to indicate the degree to which their ideal functions were actually practised by them. The core was establishing the ideal and actual role of nurse educators in the clinical

instruction process.

Views on reasons for non-participation in clinical teaching, problems encountered with clinical teaching and solutions thereto were explored. The questionnaire was pretested on five nurse educators to identify problems in phrasing of statements and in instruction.

5.2.4.3 POPULATION AND SAMPLE

The population for this study consisted of all registered nurse tutors that were currently engaged in direct education and training of nurses that were undergoing a basic nursing course. Participants consisted of sixty five (65) females and five (5) males whose ages ranged from below twenty five (25) to over fifty five (55) years. These were drawn from accessible institutions that offered the basic nursing course in Regions F and H of the KwaZulu-Natal province. Participants were assured of anonymity and confidentiality.

5.2.4.4 PROCESS OF DATA ANALYSIS

Open-ended items of the questionnaire were analysed manually and close-ended items were analysed by means of a statgraphics computer programme. Data from the Likert scale was presented in the form of tables and then collapsed horizontally into three categories. In the Ideal scale, responses 1 (Strongly Disagree) and 2 (Disagree) were classified as "Disagree". Responses 4 (Agree) and 5 (Strongly Agree) were categorised as "Agree". Uncertain and no response formed category three "Uncertain".

In the Actual Scale, responses 1 and 2 (not at all and minimally) respectively, formed category one, "Not participating". Responses 3 (Reasonably) 4 (Considerably) and 5 (Great deal), were categorised as "Participating". "No response" formed the third category. Data from horizontally collapsed codes was presented in the form of bar graphs.

5.3 RESEARCH FINDINGS

5.3.1 BIOGRAPHIC AND EDUCATIONAL DATA

5.3.1.1 GENDER

The results of this study revealed that sixty five (92,9%) and five (7,1%) respondents were female and male respectively. This shows that participants were predominantly female.

5.3.1.2 AGE GROUP

Of the seventy nurse educators who participated in this study, thirty (42,9%) fell into the age group of 35-44 years. Comparing people in this age group (middle age) and the student nurse who begins the basic course at a normal post-school learning age, as is usually the case, it can be assumed that these nurse educators have acquired enough skills and knowledge to adequately teach these neophytes.

5.3.1.3 EDUCATIONAL QUALIFICATIONS

Out of seventy nurse educators who participated, fifty nine (84,2%) respondents had a bachelor's degree and above. It can be assumed from these findings that educationally and professionally, such respondents have enough insight into the need for effective clinical teaching and into problems besetting this component of teaching and learning.

5.3.2 JOB DESCRIPTION OF NURSE EDUCATORS

From the responses given to this item, it appeared that theory teaching was the main function of nurse educators. It was heartening, however, to note that sixty three (90%) respondents indicated that their job description demanded participation in clinical instruction activities. These included:-

- * clinical accompaniment, teaching and supervision
- * clinical evaluation like participating in OSCE
- * student counselling; and
- * student allocation to clinical area.

Of the seventy (70) participants, 3 (4,3%) said there was no specific job

description for them and 4 (5,7%) did not respond to the item.

5.3.3 AVERAGE TIME SPAN FOR CLINICAL TEACHING

Twenty six (40%) out of seventy (70) nurse educators responded that they spent 3-5 hours per week in clinical teaching, followed by sixteen (24%) who indicated that they spent 6-8 hours per week. When requested to indicate whether this was an ideal function for effecting clinical instruction, twenty nine (41,4%) revealed that 6-8 hours per week would be ideal and seventeen (24,3%) opted for 3-5 hours per week.

5.3.4 NURSE EDUCATORS' ACTIVITIES IN CLINICAL AREA

Sixty four (91,4%) respondents indicated that they taught, guided and evaluated students and fifty three (75,7%) role modelled and accompanied students. An activity with the lowest score, thirty five (50%) was demonstration of nursing skills.

5.3.5 REASONS FOR NON-INVOLVEMENT IN CLINICAL TEACHING

Nurse educators who were "Not at all" participating in clinical teaching stated that clinical teaching was generally accorded low status, it gave no academic credit and it was perceived as a difficult task.

5.3.6 THE NURSE EDUCATORS' ROLE IN THE CLINICAL INSTRUCTIONAL DEVELOPMENT PROCESS

ASSESSMENT

All activities given in Item 4.12.1 (Assessment) were accepted as ideal functions of nurse educators and the degree of acceptance ranged from 72,9% to 92,8%. Nurse educators who actually participated in these activities were however, less than those who identified these as their ideal duties. The highest score indicating participation was 88,6% and the lowest was 65,7%.

PLANNING

Responses of nurse educators to extent to which planning was perceived as their

ideal function yielded positive responses ranging from 75,8% (lowest score) to 91,4%. Activities that yielded the most favourable responses were planning a learning programme and designing and revising workbooks. Scores reflecting actual participation were shockingly low, ranging from 50% to 65,7%.

IMPLEMENTATION

Implementation of clinical teaching activities seemed to receive a great deal of the nurse educators' attention. A large percentage, 71,4% to 88,6% indicated that they directly participated and these scores compared well with their perception of ideal duties which ranged from 80% to 87,1%.

EVALUATION

Evaluation of clinical teaching is another area where nurse educators fell short of their ideal. Evaluation activities were perceived as their ideal functions by 80% to 88% of respondents. Actual participation scores were as low as 41,4% and 42,9% for serving in clinical evaluation committee and moderating clinical examination results respectively.

Recording of students' records and nurse teachers' activities yielded a similar pattern of responses where scores for actually practised activities were 64,3% to 70% while 80% to 81,4% respondents agreed that record keeping is an ideal function of nurse teachers in clinical area.

5.4 CONCLUSIONS

The following conclusions were drawn from this study:-

- * Nurse educators in the area under study generally perceived clinical teaching as their function
- * Sixty two (88,5%) respondents agreed that clinical teaching is an integral part of nursing education as opposed to two (2,9%) who reported that in their opinion it was not.
- * All items/activities in the ideal scale (assessment, planning, implementation, evaluation and record keeping were accepted as

functions of nurse educators. The highest acceptance score was 91,8%. This is evidence enough that nurse teachers perceive clinical instruction as their function. (Objective 1)

* The nature of clinical activities undertaken by nurse educators seemed to tally with those mentioned in their job description. These included teaching, guiding, evaluation and counselling of students.

Responses to the items in the actual scale revealed that the extent of participation of nurse educators in clinical instruction covered all steps of the instructional process. Duration and frequency of accompaniment however, tended to be diverse. Responses to ideal and actual duration were almost converse. Ideally 24% opted to 3-5 hours and 41,4% indicated 6-8 hours. In actual practice 40% of respondents said they spend 3-5 hours per week while only 24% said they spend 6-8 hours.

From these findings it was somewhat difficult to establish whether or not any congruency existed between the job description and activities undertaken by nurse educators particularly when viewed against the fact that no specifics were given in their job description. (Objectives 2 and 3)

Nurse educators did not adequately participate in clinical instruction because of excessive workload and unacceptability by ward staff. Their own feelings of inadequacy (lack of skill and confidence) also acted as a major deterrent to fulfilling this function. (Objective 4)

It has come to light that nurse educators who are keen to undertake clinical instruction also become despondent due to problems that they experience with the clinical teaching. (Objective 5)

5.5 LIMITATIONS

5.5.1 One nursing college was not accessible for the study. The researcher failed to obtain permission even after several requests.

- 5.5.2 Financial constraint deterred the researcher from doing the study over a larger area.
- 5.5.3 The one hundred percent (100%) sample that was desired could not be obtained as some nurse educators expressed unwillingness to participate in the study. More views could have been elicited.

5.6 IMPLICATIONS OF THE STUDY

ASSESSMENT

The findings of this study show that nurse educators in the area under study acknowledge that assessment in clinical instruction is their function. They also revealed that nurse educators participate in this function, although scores reflecting participation were lower than those in the ideal scale. The activities listed in items 4.10.1 of the questionnaire in Annexure A will probably make nurse educators to be aware of assessment activities they should undertake in clinical area.

PLANNING

The high scores reflecting non-participation in planning for clinical instruction in the actual scale, should make nurse educators realise that they fall short of expectations. Responses in the ideal scale should be the yardstick against which they measure their performance in order to improve their participation in activities that they ideally perceive as their functions.

IMPLEMENTATION

The findings in this item revealed that actual instructional activities were practised and scores were as high as those given in the ideal scale. This should show nurse educators how inconsistent their clinical participation is. These findings should be an indication that nurse educators can do as well in the other phases of the instructional process. One has to wonder however, whether further probing or observation would have yielded different results as these were given in self reports.

EVALUATION

Scores yielded by responses to this item highlighted deficiencies in the performance of certain evaluation activities like moderating. Responses to the ideal scale should serve as a desired standard of participation in clinical instruction and activities in Item 4.10.4 of the questionnaire should help nurse educators to identify areas that need attention in evaluation for clinical instruction.

RECORD KEEPING

Although this item does not strictly form part of the clinical instructional process, it is essential it enables nurse educators to keep track of activities, strengths and weaknesses of the students in the clinical area. It therefore serves as a baseline record for remedial instruction.

The items in the questionnaire can then be used as a guide against which nurse educators judge their clinical participation. The checklist can be used during orientation of new nurse educators so that they know exactly what their clinical instructional role entails.

5.7 RECOMMENDATIONS

A more structured component on clinical instruction should be incorporated into the student tutors' programme to eliminate poor preparation for this component of nurse education. This would eliminate shirking of this responsibility on the grounds of lack of skills and confidence.

Clinical laboratories in institutions where these are non-existent should be provided to bridge the gap between college and service where distance between campus and practise area is a major problem. This would hopefully eliminate the group of nurse educators who do "not at all" participate in clinical teaching.

The alleged workload should be explored to establish if nurse educators are not bogged down with duties that could be done by other personnel.

A certain duration of time for clinical experience should be a requisite for entry into the nurse tutors' course. This will ensure that realities of the clinical field are deeply inculcated into the prospective tutor with the hope that she will then educate with better insight into needs of students.

Clinical instructors, where they still exist, should be part of the college or nursing science department so that they are as conversant with curricula as nurse educators are expected to be.

SUGGESTIONS FOR FURTHER RESEARCH

The study can be conducted in other regions of KwaZulu-Natal in order to determine the extent of the problem.

5.8 CONCLUSION

From this study it has become obvious that many barriers still exist that prevent nurse educators from adequately fulfilling the clinical teaching function. It appears that the nature of clinical accompaniment and the quality thereof is still a debatable issue. One even wonders whether research studies should not be conducted to establish if there is a dire need for nurse educators to do clinical instruction when there are still clinical instructors who have the same educational qualifications as college tutors doing it. In her theme song at the International Nursing Conference : Nursing at the cutting edge - caring for the 21st century, Sharon Katz said:- "*there are more questions than answers*". This is true of clinical teaching and nursing education. The controversy surrounding this issue is far from being resolved.

REFERENCES

1. Alberts, U.U.; (1991). An inquiry into the degree of involvement among nurse tutors in clinical teaching at certain teaching centre in South Africa. National Nursing Research Register, Vol VIII. Pretoria : South African Nursing Association.
2. Abraham, C. & Shanley, E.; (1992). Social psychology for nurses. London : Edward Arnold.
3. Biddle, B. & Thomas, E.; (1966). Role theory : Concepts and Research. New York : John Wiley & Sons Inc.
4. Brink, H.I.L.; (1984). The registered nurse tutors in the Republic of South Africa. Doctoral Thesis. Pretoria : University of South Africa.
5. Broussard, A.B.; Deloussaye, C. & Poirier, G.P.; (1996). The practice role in the academic nursing community. Journal of Nursing Education, Vol 35, No 2, pg 82-86.
6. Campbell, J.M. & Kinion, E.S.; (1993). Teaching leadership/fellowship to RN to MSN students. Journal of Nursing Education, Vol 32, No 3, pgs 138-139.
7. Canales, M.; (1994). Clinical education : A caring approach. Journal of Nursing Education, Vol 33, No 9, pgs 417-419.
8. Carpenito, L.J. & Duespohl, A.T.; (1984). A guide for effective clinical instruction, Second edition. Rockville : Aspen Systems Corporation.
9. Castledine, G.; (1994). Encouraging teachers back into clinical practice. British Journal of Nursing, Vol 3, No 19, p1000.

10. Cele M.G.; (1990). Clinical instruction of students in training schools in KwaZulu. Masters Dissertation. Pretoria : University of South Africa.
11. Chan, A.C.; (1995). Socialisation in French P. (Editor). The nurse, self and society : An introduction to applied sciences for nurses and health care professionals, pgs 33-141. Hong Kong : Waverly Info-Med Ltd.
12. Charon, J.M.; (1989). Symbolic interaction : An introduction, an interpretation, an integration. New Jersey : Prentice-Hall.
13. Clifford, C.; (1994). Assessment of clinical practice and the role of the nurse teachers. Nursing Education Today, Vol 14 No 4, pgs 272-277.
14. Clifford, C.; (1995). The role of the nurse teacher : concerns, conflicts and challenges. Nurse Education Today, Vol 15, pgs 11-16.
15. Clifford, C.; (1996). Nurse teachers' clinical work : A survey report. Journal of Advanced Nursing, Vol 23, pgs 603-611.
16. Clifford, C.; (1996). Role : A concept explored in Nursing Education. Journal of Advanced Nursing, Vol 23, pgs 1135-1141.
17. Crotty, M. (1993). Clinical role activities of nurse teachers in project 2000 programmes. Journal of Advanced Nursing 18, pg 3460-3466
18. Davies, S.; White, E.; Riley, E. & Twinn, S.; (1996). How can nurse teachers be more effective in practice settings. Nurse Educator Today, Vol 6, pgs 19-27.
19. de Tornyay, R. & Thompson, M.A.; (1987). Strategies for teaching nursing. New York : Wiley & Sons.

20. Doherty, M. & Cook, C. (1988). The discipline of nursing, 2nd edition.
New York : Churchill Livingstone.
21. Fain, J.A.; (1987). Perceived role conflict, role ambiguity and job satisfaction among nurse educators. Journal of Nursing Education, Vol 26 No 6, pgs 233-235.
22. Fawcett, T.N. & McQueen, A.; (1993). Clinical credibility and the role of the nurse teacher. Nurse Education Today, Vol 14, pgs 264-271.
23. Ferguson, S.; (1996). The lived experience of clinical educators. Journal of Advanced Education, Vol 23, pgs 825-841.
24. French, P.; (1995). The nurse, self and society : An introduction to applied behavioural science for nurses and health care professionals. Hong Kong : Waverly Info-Med Ltd.
25. Goodchild-Brown, B.; (1989). Accompaniment of students by nurse teachers : A brief didactic study, pgs 54-58. In Tjalinks, J. (Compiler) : Reader for NUE203-D. Nursing Ethics. Pretoria : University of South Africa.
26. Grimm, J.W. & Wozniak, P.R.; (1990). Social statistics and quantitative Research methods. Belmont : Wadsworth Publishing Co.
27. Guinee, K.K.; (1978). Teaching and learning in nursing. New York : McMillan Publishing Co.
28. Gunter, C.F.G.; (1980). Aspects of Educational Theory. Stellenbosch/Grahamstown : University Publishers.

29. Hardy, M.E. & Conway, M.E.; (1978). Role Theory : Perspectives for health Professionals. New York : Appleton-Century Crofts.
30. Harri, M.; (1996). "I love my work, but ..." The "best" and the "worst" in a nurse educators' working life in Finland. Journal of Advanced Nursing, Vol 23, pgs 1098-1109.
31. Hartley, D. & Aukamp, V.; (1994). Critical thinking ability among nurse educators and nursing students. Journal of Nursing Education, Vol 33 No 1 pgs
32. Hinchliff, S.A.; (1986). Teaching clinical nursing. New York : Churchill Livingstone.
33. Hlatshaneni, M.B. & Masinga E.B.; (UNDATED). Philosophy of Education I Study Guide. KwaDlangezwa : University of Zululand.
34. Hooper, E.; (1981). Social Mobility, 1st Edition. Southampton : Camelot Press.
35. Infante, S.I.; (1985). The clinical laboratory in Nursing Education, 2nd edition. New York : John Wiley & Sons.
36. Jordaan, M. & Jordaan F.; (1984). Man in context. Johannesburg : McGraw-Hill Company.
37. Karuhjie, H.I.; (1986). Educational Preparation for clinical teaching : Perceptions of nurse educators. Journal of Nursing Education, Vol 25 No 4, pgs 138-144.
38. Kenworthy, N. & Nicklin, P.; (1989). Teaching assessment in nursing practice : An experiential approach. London : Scutan Press.

39. Kopala, B.; (1994). Conflict in nurse educators' role obligations. Journal of professional nursing, Vol 10, No 4, pgs 236-242.
40. Krichbann, K.; (1994). Clinical teaching effectiveness described in relation to learning outcome of Baccalaureate nursing students. Journal of Nursing Education, Vol 33, No 7, pgs 306-314.
41. Kruger, R.A. & Muller, E.C.C.; (1988). Learning structure and teaching process. Pretoria : Rands Afrikaans University.
42. Lee, D.T.F.; (1996). The clinical role of the nurse teacher : A review of the dispute. Journal of Advanced Nursing, Vol 33, pgs 1153-1154.
43. Martin, L.; (1989). Clinical education in perspective. London : Stutan Press.
44. Mashaba, T.G.; (1986). The socio-economic status of black students and its implications for nursing education, Series B No 65. KwaDlangezwa : University of Zululand Publications.
45. Mashaba, T.G.; (1994). The status of the students undertaking the basic nursing course. Nurse Education Today, Vol 14, pgs 306-313.
46. Mashaba, T.G. & Brink, H.I.L.; (1994). Nursing Education : An international Perspective. Kenwyn : Juta & Co. Ltd.
47. Mashaba, T.G. & Mhlongo T.; (1995). Student nurse wastage : A case study of the profile and perceptions of students of an institution. Journal of Advanced Nursing, Vol 22, pgs 364-373.
48. Mason, G. & Jinks, A. (1994). Examining the role of the practitioner-teacher in nursing. British Journal of Nursing, Vol 3, No 20, pgs 1063-1071.

49. Mellish, J.M. & Brink, H.I.L. (1987). Teaching the practice of nursing, 3rd edition. Durban : Butterworths.
50. Mellish, J.M. & Brink, H.I.L. (1989). Teaching the practice of nursing, Fourth edition. Durban : Butterworths.
51. Mellish, J.M. & Brink, H.I.L. (1992). Teaching the practice of nursing, Fifth edition. Durban : Butterworths.
52. Menard, S.W.; (1987). The clinical nurse specialist : Perspectives on practice. New York.
53. Merton, R.R.; (1957). Social theory and social structure. New York : Free Press.
54. Morrall, P.; (1995). Roles. In French P. (Editor). The nurse, self and society : An introduction to applied sciences for nurses and health care professionals, pgs 133-141. Hong Kong : Waverly Info-Med Ltd.
55. Myrick, F.; (1991). The plight of clinical teaching in Baccalaureate nursing education. Journal of Nursing Education, Vol 30 No 1, pgs 44-46.
56. Nelms, T.P.; Jones, J.M.; & Gray, D.P.; (1993). Role modelling : A method for teaching caring in Nursing Education. Journal of Nursing Education, Vol 32, No 1, pgs 18-23.
57. Orchard, C.; (1991). The nurse educator and the nursing student : A review of the issue of clinical evaluation procedures. Journal of Nursing Education, Vol 33 No 6, pgs 245-250.
58. Owen, C.P.; (199). A policy for the development of a district health system in South Africa. Pretoria : Department of Health.

59. Parker, J.L.; (1994). Education for clinical practice : an alternative approach. Journal of Nursing Education, Vol 33 No 9, pgs 411-415.
60. Pennebaker, D.; (1995). Groups. In French, P. (Editor). The nurse, self and society : An introduction to behavioural sciences for nurses and health care professionals, pgs 213-229. Hong Kong : Waverly Info-Med Ltd.
61. Polit, D.F. & Hungler, B.P.; (1987). Nursing research-principles and methods, 3rd Edition. Philadelphia : J.B. Lippincott Co.
62. Quinn, F.M.; (1988). Principles and practice of nurse education. London : Croom Helm.
63. Reilly, D.E. & Oermann, M.H.; (1985). The clinical field : its use in nursing Education. New York : Appleton-Century Crofts.
64. Schlenkler, B.; (1985). The self and the social life. New York : McGraw-Hill Book Co.
65. Schoenly, L.; (1994). Teaching in the affective domain. The Journal of Continuing Education in Nursing, Vol 25, No 5, pgs 209-212.
66. Searle, C.; (1985). Nursing Administration, Only Guide for NUA 100. Pretoria : University of South Africa.
67. Smith, D.W.; (1977). Perspectives on clinical teaching, Vol 2. New York : Springer Publishing Co.
68. SOUTH AFRICAN NURSING COUNCIL REGULATIONS. R425 OF FEBRUARY 1985.

69. SOUTH AFRICAN NURSING COUNCIL REGULATIONS. TERMINOLOGY LIST, Pretoria, South African Nursing Council.
70. Strader, M. & Decker, P.; (1995). Role transition to patient care management. Norwalk : Appleton & Lange.
71. Streubert, H.J.; (1994). Male nursing students' perception of clinical experience. Nurse educator, Vol 19, No 5, pgs 28-32.
72. Uys, L.R.; (1992). Dilemmas of clinical teaching. Curationis, Vol 15 No 4, pgs 22-27.
73. van HOOZER, H.L.; Bratton, B.D.; Oestmoe, P.M.; Weinholtz, D.; Craft, M.J.; Gjerde, C.L. & Albanese, M.A.; (1987). The teaching process : Theory and practice in nursing. Norwalk : Appleton-Century Crofts.
74. Windsor, A.; (1987). Nursing students' perceptions of clinical experience. Journal of Nursing Education, Vol 26, No 4, pgs 150-153.
75. Woodrow, P.; (1994). Role of the lecturer-practitioner : 1. British Journals of nursing, Vol 3, No 11, pgs 571-575.
76. Woodrow, P.; (1994). Role of the lecturer-practitioner : 2. British Journals of nursing, Vol 3, No 12, pgs 611-612.
77. Woolfolk, A.E.; (1990); Educational Psychology, 4th edition. London : Prentice-Hall International.

ANNEXURE A

Enquiries: 0351 - 93911 ext 2448

University of Zululand
Private Bag X 1001
Kwa-Dlangezwa
3886

Dear Colleague

Kindly find enclosed a questionnaire which is addressed to all nurse educators who are currently engaged in Nursing Education and training of student nurses doing a Basic nursing course.

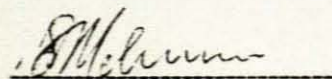
This is part of a research project for an M A Cur degree in Nursing Education.

In order to ensure the success of this research kindly answer as honestly as you can. Your opinion, perception and thoughts are of utmost importance for the study.

All information will be kept in strict confidence. Do not write your name anywhere so as to ensure anonymity.

Thank you in advance for your co-operation.

Yours sincerely



S.A. MCHUNU

SECTION A

DEMOGRAPHIC, EDUCATIONAL AND PROFESSIONAL DATA

Kindly answer each question by inserting a tick () in the most appropriate block opposite an item unless otherwise stipulated.

1. PERSONAL DATA

1.1 Gender

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>

1.2 Age group

Less than 25 years	<input type="checkbox"/>
25 - 34 years	<input type="checkbox"/>
35 - 44 years	<input type="checkbox"/>
45 - 54 years	<input type="checkbox"/>
55 and above	<input type="checkbox"/>

2. NURSING EDUCATIONAL DATA

2.1 Basic Nursing Programme undergone

SANC Diploma	<input type="checkbox"/>
Nursing College integrated course	<input type="checkbox"/>
University Bachelor's degree	<input type="checkbox"/>
Other (Please specify)	<input type="checkbox"/>

2.2 Post-Basic/Programme completed for registration as a nurse tutor

University Diploma	<input type="checkbox"/>
Post registration Bachelor degree	<input type="checkbox"/>
Single subject after degree	<input type="checkbox"/>

2.3 Highest professional qualification you currently hold

Post Basic diploma	<input type="checkbox"/>
Bachelor degree	<input type="checkbox"/>
Honours degree	<input type="checkbox"/>
Masters degree	<input type="checkbox"/>

Doctoral degree	
Other (Please specify)	

3. PROFESSIONAL STATUS

3.1 Professional title/position

Tutor	
Principal	
Lecturer	
Professor	
Other (Please specify)	

3.2 Indicate courses/subjects that you currently teach

General Nursing Science	
Midwifery	
Psychiatric Nursing	
Community Health Nursing	

SECTION B

4. PARTICIPATION OF NURSE EDUCATORS IN CLINICAL INSTRUCTION

4.1 What is your job description as a nurse educator?

.....

.....

.....

.....

4.2 Do you participate in clinical instruction?

Yes	
No	

4.3 If answer to 4.2 is YES, state your reasons for participation.

Necessary for student growth and development	
SANC requirement	
Faculty/Departmental requirements	
Strictly allocated by head of section	
Other (Please Specify)	

4.4 If answer to 4.2 is NO, state your reasons for not participating.

Overburdened with teaching duties	
Have subordinates to do it	
Not responsibility of nurse educator	
Do not like it	
Lack of clinical skills/confidence	
Lack of peer support in ward	
Do not feel it is necessary	
Not taught during role taking	
Other (Specify)	

4.5 (Omit if answer 4.2 was NO) On average how many hours do you spend in clinical teaching.

1 - 2 hours a week	
3 - 5 hours a week	
6 - 8 hours a week	
More than 8 hours a week	

4.5.1 Does this measure up to your job description

Yes	
No	

4.5.2 Is this adequate? Motivate

.....

.....

.....

4.6 Indicate the activities you mostly engage in during such visits.

Plain clinical teaching programmes	
Design tools and procedures	
Accompany students	
Evaluate students	
Teach and guide students	
Do continuous assessments	
Demonstration of among skills	
Role modelling professional behaviour	
Other (Specify)	

4.7 In your opinion, is clinical instruction an integral part of nursing education?

Yes	
No	
Uncertain	

4.8 If answer to 4.7 is NO, whose function, in your opinion is clinical instruction? Why?

.....

.....

.....

4.9 In your opinion how long should nurse educators spend in clinical area?

1 - 2 hours per week	
3 - 5 hours per week	
6 - 8 hours per week	
More than 8 hours per week	

	ALWAYS	SOMETIMES	NEVER
4.11 Do you experience any problems with clinical instruction			

4.12 What kind of problems do you experience and what do you think are the solutions for these problems?

PROBLEMS	POSSIBLE SOLUTIONS

Thank you for co-operating and participating in this research.

ANNEXURE B

DEPARTMENTAL POLICY FOR CLINICAL INSTRUCTION : TUTORS.

1. The tutor is a teacher of all nursing i.e. both classroom and clinical instruction. Nursing Science Art is a major subject of nursing diplomas therefore, must be taught with utmost care and diligence.
2. The tutor is expected to assume a leadership role in clinical instruction. The implication being that whatever delegation she may make should not result in surrender of her responsibility for clinical instruction.
3. The tutor should spend a minimum of 8 hours a week at the clinical setting. The time spent in the wards will gradually increase as more and more clinical instructors qualify for registration as tutors and become appointed as such.
4. The tutor has the following responsibility in relation to clinical instruction :-
 - 4.1. She is the leader of all activities related to clinical instruction.
 - 4.2. She prepares learning objectives to be attained during a clinical placement. She explains these to sister in charge of a training ward and the clinical instructor.
 - 4.3. She prepares the student's clinical work book and revises it from time to time.
 - 4.4. She explains to the ward sisters and clinical instructors how the workbook is to be used.
 - 4.5. She inspects and approves the work programme of clinical instructors working under her.

- 4.6. She monitors the productivity of the clinical instructors.
- 4.7. She inspects the student's work book to see if the student is making satisfactory progress. Unsatisfactorily progress is brought to the attention of the student concerned and if necessary also to the attention of the Principal.
- 4.8. The tutor should co-ordinate activities of all who undertake instruction so that unnecessary overlaps and leaving of certain areas under-taught or neglected are avoided.
- 4.9. She engages in demonstrating of nursing skills, supervision of student nurses while they give nursing care and assesses proficiency in the care.
- 4.10. All records of clinical learning are her responsibility but can be delegated to the clinical instructor.
- 4.11. She is responsible for all arrangements for practical examinations.

SIGNED:

DATE:

PROVINCE OF
KWAZULU-NATAL

DEPARTMENT OF HEALTH

ISIFUNDAZWE
SAKWAZULU-NATALI

UMYANGO WEZEMPILO

PROVINSIE
KWAZULU-NATAL

DEPARTEMENT VAN GESONDHEID

NATALIA
330 LONGMARKET ST
PIETERMARITZBURG

TEL. 0331-952111

FAX 0331-426744

Private Bag : X9051
Isikhwama Seposi : Pietermaritzburg
Privaatsak : 3200

ANNEXURE C

REFERENCE: 66/3
ENQUIRIES: Dr L.L. Nkonzo-Mtembu
TELEPHONE: 95-2721

DATE: 22 July 1996

Ms S.A. Mchunu
University of Zululand
Private Bag X1001
KWA DLANGEZWA
3886

Dear Madam

RE RESEARCH PROJECT "AN INVESTIGATION INTO NURSE EDUCATORS'
PERCEPTION OF THEIR CLINICAL INSTRUCTION ROLE"

Dr P. Emerson, Acting Chief Director, has given permission for you to approach the Campus Principals of Addington, King Edward VIII and R.K. Khan Hospitals in respect of the above research.

Yours faithfully



SECRETARY : DEPARTMENT OF HEALTH
KWAZULU-NATAL

LLNM/rcb/s.j26

ANNEXURE D



University of Natal

Faculty of Social Science
Department of Nursing

Private Bag X10, Dalbridge 4014 South Africa
Telephone (031) 2602499
Fax (031) 2601543

22nd January, 1996

Ms S A Mchunu
University of Zululand
Private Bag X1001
KWA-DLANGEZWA
3886

Dear Ms Mchunu

Thank you for your letter dated 12/12/95. You have my permission to undertake your survey research in this Department.

Wishing you every success in your studies.

Sincerely

PROF L R UYS
(HEAD OF DEPARTMENT)

**University of
Universiteit van
Zululand:**



Private Bag X10
Privaatsak X10
ISIPINGO 4110
031 9075055
6-28081 SA
FAX: 9073011

UMLAZI EXTRAMURAL DIVISION
BUISTEMUURSE AFDELING

25 JUNE 1996

MISS S.A. MCHUNU
LECTURER: NURSING SCIENCE DEPARTMENT
UNIVERSITY OF ZULULAND
PRIVATE BAG X1001
KWADLANGEZWA
3886

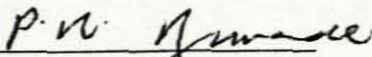
Dear Miss Mchunu

PERMISSION TO CONDUCT RESEARCH

Further to your letter dated 9 May 1996, it is with pleasure that I must inform you that permission is granted to you to conduct research at the Main and Umlazi Extramural campuses provided that:-

1. Ethical considerations are respected for subjects;
2. The report is submitted to the department on completion of your study.

Yours sincerely


PROF P.N. NZIMANDE
HEAD OF DEPARTMENT - NURSING SCIENCE



**ST. AUGUSTINE'S
HOSPITAL [PTY]LTD**

Reg. No. 83/04629/07

A CLINIC HOLDINGS LIMITED
GROUP COMPANY

107 Chelmsford Road,
Durban 4001

☒ 30105 Mayville, 4058

☎ [031] 21-1221

☒ [031] 21-4598

23 May 1996

Miss S A Mchunu
Lecturer : Nursing Science Dept.
University of Zululand
Private Bag X1001
KWADLANGEZWA
3886

Dear Madam

RESEARCH PROGRAMME

I am in receipt of your letter of 13 May 1996, requesting permission to conduct research in this hospital.

It will be in order for you to submit questionnaires to our nurse educators and I suggest you contact the Principal of our training school, Mrs R Goosen, in this regard.

Yours faithfully

Miss A F Watson
SENIOR NURSING SERVICE MANAGER

ANNEXURE G

NGWELEZANA NURSING COLLEGE
PRIVATE BAG X 20016
EMPANGENI
3880

21 NOVEMBER 1996


MISS S.A MCHUNU
UNIVERSITY OF ZULULAND
PRIVATE BAG X 1001
KWA - DLANGEZWA
3886

Dear Miss Mchunu

Thank you for your letter dated 20/11/96 .

I am glad to inform you that permission has been granted for you to undertake your survey research in this College.

I wish you all the luck in your studies.



ACTING PRINCIPAL
MRS N.N. MAHLASELA