A STUDY OF CLINICAL INSTRUCTION PRACTICE OF NURSE EDUCATORS AND PROBLEMS THEREOF

BY

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SUBMITTED :- JANUARY 1999

DECLARATION

I Thembekile Masango-Mtetwa declare that "The study of clinical instruction practice of Nurse Educators and problems thereof" is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

....
T. MTETWA

DEDICATION

This work is dedicated to:-

1. My beloved late mother Florah Nobelungu who nurtured in me the will and enthusiasm to learn. Her spirits continue to guide me.

2. My family for their unfailing support and encouragement to pursue my studies.

3. All my friends and those who stood by me when things were difficult.

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I wish to express my sincere gratitude and appreciation to all the people who gave their full support and assisted me in various ways during the conduct of the study.

I am greatly indebted to my supervisors Prof T.G. Mashaba and Mrs C.S. Mhlongo for their wise guidance constructive comments, academic help and encouragement which contributed to success in completing the study.

I also wish to acknowledge with much appreciation the contributions of the following:-

- The KwaZulu-Natal Department of Health for having given me permission to conduct the study.
- The Senior Medical Superintendent of Ngwelezane Health ward and the principals of Ngwelezane Nursing College Campus and its satellite campuses.
- The nurse educators who participated in the study.
- The University of Zululand for the financial assistance given to me towards the conduction of the study.
- The authors whose works have been cited.
- Mrs D. Ngcongo for typing my document.
- My friends and colleagues for their input and suggestions.

ABSTRACT

This study deals with the clinical instruction practice of nurse educators and problems/ constraints they encounter during clinical teaching. It is a descriptive survey that attempted to:-

- elicit the views of nurse educators regarding their role in clinical instruction.
- determine the extent to which nurse educators participate in clinical instruction.
- identify and describe what nurse educators consider to be the major constraints in clinical instruction.

The experiential learning theory formed the conceptual framework of the study.

The institutions targeted were Nursing Colleges located in Regions D, G and H of KwaZulu-Natal Province in South Africa. A questionnaire was used to elicit information from nurse educators directly engaged in the education and training of student nurses undergoing the basic comprehensive four year diploma programme at afore-mentioned institutions.

The findings indicated that nurse educators view assessment, planning, implementation and evaluation of clinical teaching and learning as their ideal function. However, several problems and constraints (both at college and clinical area) were identified by nurse educators as militating against effective execution of clinical teaching. Some of the problems mentioned include overload of work, lack of clinical facilties and negative attitude by some nurse educators and student nurses towards clinical teaching and learning.

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Clinical instruction in nursing is central to the development and socialisation of student nurses. It provides the final input for learning, that is, interaction in an environment containing clients/ patients and other health professionals. Over and above, it offers students the opportunity to apply knowledge they have gathered and to practise the art of caring.

Clinical instruction is a method specifically concerned with interpretation in a nursing context of Maslow's theory of human needs with a view of meeting the many varied patients' needs encountered in the clinical setting. Since its conception, nursing has been considered to be having both science and art components. The science involves a body of abstract knowledge and the art involves the creative use of knowledge to serve people. This study aims to determine the extent to which nurse educators participate in assisting student nurses to integrate theory to practice so that they become skilled, competent and committed professional practitioners of nursing accountable to their patients, society and their profession.

1.2 BACKGROUND TO THE PROBLEM

Traditionally, clinical instruction has been the responsibility of the unit professional nurses and clinical instructors. Until quite recently there were two types of nurse teachers, namely the nurse educator or tutor whose primary responsibility was teaching in the classroom and the clinical teacher whose primary responsibility was teaching in practice placement settings. With the developments in the nursing profession, the responsibility for clinical instruction is now considered by some leading nurse educationists, first and foremost the responsibility of tutors/ nurse educators and to a lesser extent of the head-nurse in charge of the nursing unit (Searle, Campbell & Ehlers 1986: 251). A new title of lecturer / practitioner, a qualified teacher who has retained clinical competence has emerged. These developments have made it incumbent upon nurse educators to teach theory in the classroom situation and then proceed to the clinical area to correlate what they have taught into practice (Quinn 1995:185). The nurse educator should accompany student nurses to ensure that nursing skills are carried out safely, kindly and with confidence. He/ she must be there to give guidance, academic and moral support to the student to avoid trial-and-error learning which can have a dangerous and sometimes fatal effect on the patient.

1.3 MOTIVATION

The researcher has been working in an institution that provides clinical

learning experiences for both basic degree students and students of the four year comprehensive diploma course for almost twelve years. This somewhat lengthy exposure enabled the researcher to identify a need to undertake this study out of concern that nurse educators seem to be unwilling to accept responsibility for clinical instruction. Through informal discussions with some of them, they actually spell it out that clinical instruction is the responsibility of unit professional nurses. Some verbalise lack of confidence for hands-on nursing. They put forward the following factors that hinder their involvement in clinical teaching:-

- college commitments prevent them from doing so
- ward staff resent their presence
- lost of contact with the reality of nursing care
- lack of confidence in the ability to cope in the wards.

On the other hand unit professional nurses are very vocal about their primary responsibility namely, provision of nursing care to patients. They view teaching of student nurses as their secondary function. In fact most unit professional nurses are out of touch with the theoretical principles which make correlation of theory to practice difficult for them. The nurse educator, according to the researchers opinion, is the best person to provide clinical teaching because he/ she possesses the necessary skills to put together

different elements of different subject areas for presentation into distinct nursing perspective.

Student nurses also allege that clinical instruction is provided on an ad hoc basis and others express concern about lack of ward-based training. These sentiments are shared by Robertson (1980: 13) who expressed problems with the organisation of clinical teaching which was often left to the discretion of ward staff and was haphazardly executed. These put the student in a very invidious position because nobody is apparently available for clinical teaching, it appears to be "nobody's job" or neglected. A poorly co-ordinated or ineffective execution of a clinical teaching programme is seen by the researcher as causing a gap between theory and practice which is indeed a pressing problem for the nursing profession.

1.4 STATEMENT OF THE PROBLEM

There is an apparent lack of participation of nurse educators in the clinical instruction of student nurses. Nurse educators appear to be attracted to administrative and other college-based roles to such an extent that student accompaniment is jeopardised.

This study therefore attempts to answer the following questions:

(1) What are nurse educators' views regarding their clinical teaching role?

(2) To what extent do nurse educators participate in clinical instruction?

(3) What do nurse educators consider to be the major constraints in clinical teaching?

1.5 OBJECTIVES OF THE STUDY

The researcher will be guided by the following objectives throughout the study:-

1. To elicit the views of nurse educators regarding their role in clinical instruction.
2. To determine the extent to which nurse educators participate in clinical instruction.
3. To identify and describe what nurse educators consider to be the major constraints in clinical instruction.

1.6 SIGNIFICANCE OF THE STUDY

There is a widespread perception, even amongst doctors that the product of the basic degree and comprehensive diploma programmes possesses an in-depth knowledge of theory with very poor practical skills. Although one of the contributing factors could possibly be the fact that students of these programmes spend more time in the classroom than in the clinical setting, the researcher considers lack or poor clinical teaching by nurse educators as the

fundamental problem. It is here that the importance of this study comes in. It is intended to sensitize and conscientise nurse educators regarding their responsibility to demonstrate knowledge of the subject matter in the art of clinical instruction. Data obtained would probably elicit weaknesses and hopefully, suggestive solutions as to how shortcomings could be resolved. The long term objective of the researcher (using data obtained from this study) is to contribute to the development of a model of clinical instruction that would provide guidelines on how best clinical teaching could be effected. This is important because students and new graduates regardless of the breadth and depth of their knowledge, feel insecure and incompetent unless their technical skills are fairly developed.

1.7 ORGANISATION OF NURSING COLLEGES IN KWAZULU-NATAL PROVINCE

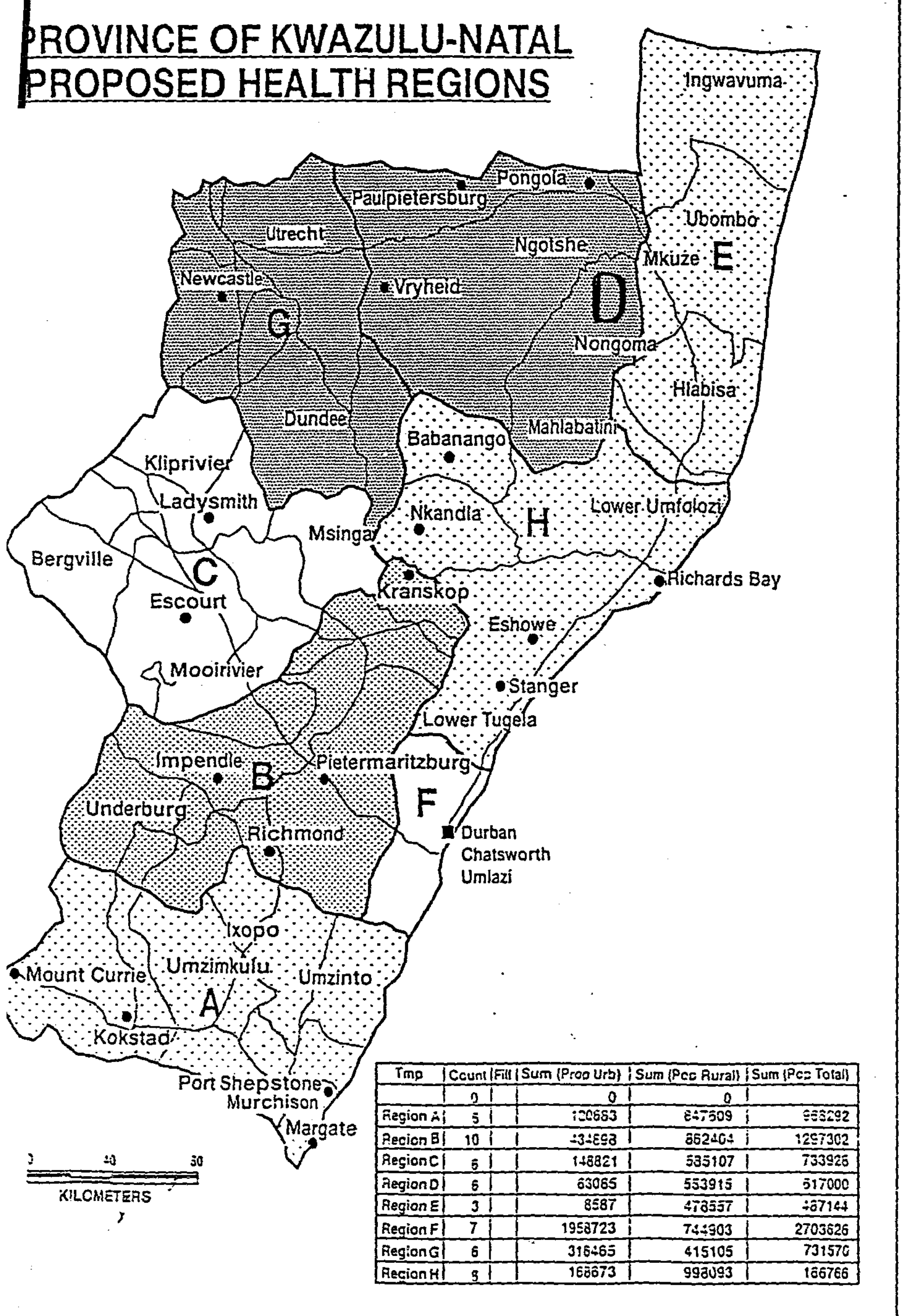
Following the inauguration of a democratically elected government in 1994, KwaZulu-Natal health services were divided into nine (9) regions (identified by means of alphabets) for the purpose of effective administration. Each region has either a nursing school and or a nursing college as well as a district or regional hospital with a number of satellite clinics. The nursing colleges are autonomous institutions of tertiary learning situated apart from hospitals' administration. This is in accordance with the South African Nursing Council regulation, R425 of February, 1985, as amended, which laid down conditions

under which nursing colleges should be established. The colleges established are:-

Ngwelezane Nursing College situated about 10 km from Empangeni town and located in Region H. This college is regarded as the main campus and has two satellite campuses namely:-

- Benedictine nursing college situated at Nongoma magisterial district near Ulundi and belongs to region D.

- Charles Johnson Memorial nursing college situated at Nqutu magisterial district near Dundee and belongs to region G.



Tmp	Count	Fill	Sum (Pop Urb)	Sum (Pop Rural)	Sum (Pop Total)
	0		0	0	
Region A	5		120683	847609	968292
Region B	10		434898	862404	1297302
Region C	6		148821	585107	733928
Region D	6		63065	553915	517000
Region E	3		8587	478557	487144
Region F	7		1958723	744903	2703626
Region G	6		316465	415105	731570
Region H	9		168673	998093	166766

figure 1.1 MAP OF KWAZULU-NATAL PROVINCE

The nursing education programmes of these two satellite campuses are supervised by the principal of Ngwelezane nursing college. The students of the main and satellite campuses follow the same curriculum and write the same examinations. The college is affiliated to the University of Zululand.

Edendale nursing college situated at Pietermaritzburg metropolitan area and belongs to region B. This college has one satellite campus that is:-

- Prince Mshiyeni Memorial nursing college in Durban metropolitan area and belongs to region F. Edendale nursing college is affiliated to the University of South Africa.

- King Edward VIII nursing college; Addington nursing college; R.K. Khan nursing college situated in Durban metropolitan area belong to region F. They are affiliated to the University of Natal.

- Madadeni nursing college is situated at Newcastle metropolitan area and belong to region G. It is affiliated to the University of South Africa.

All these nursing colleges offer a four year comprehensive diploma course but Madadeni college only offers the psychiatric component to students of

Ngwelezane nursing college and its campuses as well as to basic degree students of the University of Zululand (see figure 1.1).

1.8 CLINICAL FACILITIES FOR COLLEGES IN KWAZULU-NATAL

Nursing students utilize clinical facilities of hospitals and clinics near which their respective colleges are physically situated.

Edendale and Prince Mshiyeni Memorial hospitals and clinics attached to them offer opportunities for clinical experience to students of Edendale nursing college.
Ngwelezane, Benedictine and Charles Johnson Memorial hospitals and clinics attached to them offer opportunities for clinical experience to students of Ngwelezane nursing college.
King Edward VIII hospital and its satellite clinics offer clinical learning experience for students of King Edward VIII nursing college.
Madadeni hospital and its satellite clinics offer clinical learning experience, in psychiatric nursing to students of Madadeni nursing college as well as Ngwelezane nursing college respectively.
Addington and R.K. Khan hospitals and their clinics offer clinical learning opportunities for students of Addington and R.K. Khan nursing colleges.

1.9 CONTROL OF NURSING EDUCATION IN KWAZULU-NATAL

Control of nursing education in KwaZulu-Natal remains the responsibility of the South African Nursing Council. The council prepares broad curricula objectives and lays down conditions for the approval of nursing colleges. Although examinations are set and marked by the nursing colleges which also award diplomas, the South African Nursing Council lays down minimum requirements for registration which remains its responsibility after notification by the principal of the nursing college. In accordance with the provision of the South African Nursing Council Regulation, R425 of 1985 as amended, the nursing colleges operate in co-operation agreements with the universities that have nursing departments. Each university's department of nursing science attempts to uplift the standards of performance of the nursing college affiliated to it by:-

- working with staff of the nursing college in developing curricula.
- acting as moderators of examination papers.
- serving as appointed members of both nursing college senate and council.
- appointing and promoting of staff of the college.

The nursing colleges award diplomas endorsed by the universities with which they have cooperation agreements to the effect that training and education was

undertaken under the co-operation agreements (Cele 1990:10).

1.10 SCOPE AND LIMITATIONS OF THE STUDY

The research study was confined to nurse educators currently teaching at Ngwelezane nursing college and its two satellite campuses namely Charles Johnson Memorial and Benedictine nursing colleges. Findings from this study will thus be applicable to nursing colleges of regions H, G and D.

1.11 DEFINITION OF TERMS

To facilitate clarity of content and to enable readers to have the same understanding as the researcher with regard to key concepts used in this study, the following operational definitions have been developed:-

1.11.1 **Clinical instruction/ teaching**

Clinical instruction/ teaching is defined by Mellish & Brink (1990:217) as the means by which student nurses learn to apply the theory of nursing so that an integration of theoretical knowledge and practical skills in the clinical situation becomes the art and science of nursing. In this study clinical teaching or instruction refers to teaching of students in the clinical area where there are clients and patients.

1.11.2 Nurse educator or nurse tutor

Nurse educator or tutor is defined as a nurse who teaches nursing in a formalised education setting (Dohemy, Cook & Stopper 1988:26).

Generally it means a registered nurse who has an additional qualification of a nurse tutor as recognised by the South African Nursing Council (SANC). Contextually it will refer to a registered nurse tutor who is directly engaged in the education and training of student nurses and is currently employed at the nursing college.

1.11.3 Student nurse

The Nursing Act, 1978 (Act No. 50 of 1978) as amended defines a student nurse as a person undergoing education and training at an approved nursing college and who has complied with the prescribed conditions and has furnished the prescribed particulars. In this context, the student nurse will refer to a person doing the comprehensive four year diploma course at one of the nursing colleges under study.

1.11.4 Comprehensive four year diploma course

This is a basic nursing course offered only at nursing colleges which have entered an agreement of association with a University that has a department of nursing science. Successful completion of the course leads to registration

as a nurse (general, psychiatric and community) and midwife. It is offered in terms of the South African Nursing Council regulation (R425 of 22 February 1985) as amended.

1.11.5 Satellite campus

A satellite campus in this study refers to a branch of the main campus which although physically removed from it, is for all intents and purposes regarded as part of the main campus.

1.11.6 Accompaniment in nursing education

The South African Nursing Council defines accompaniment in nursing education as directed assistance and support by a registered nurse or registered midwife to a student or pupil nurse to become a competent practitioner. In the case of a student, growth occurs to the level of independent practice (S.A.N.C. Terminology List 1994:2). In this study accompaniment will refer to guidance, support, direction and supervision of the student nurse by the nurse educator in the clinical setting.

1.12 ORGANISATION OF THE STUDY

Chapter 1 presents the background to the problem, statement of the problem, organisation of nursing colleges in KwaZulu-Natal Province, objectives of the study, definition of special concepts used in this study and organisation of the

study.

Chapter 2 will present a review of literature, namely, books, journals and studies pertaining to the clinical instruction practice of nurse educators.

Chapter 3 will present a discussion of the theoretical framework of the study.

Chapter 4 will present a discussion of research methodology that will be used.

Chapter 5 will present analysis and interpretation of data collected from nurse educators.

Chapter 6 will give a report on findings, conclusion, limitations, implications of findings and recommendations.

1.13 CONCLUSION

In this chapter, an orientation to the study has been made. Aspects covered include: introduction, background to the study, statement of the problem, motivation for the study, objectives of the study, significance of the study, scope and limitations of the study, organisation of nursing colleges in KwaZulu-Natal province, definition of key concepts and the organisation of the study.

CHAPTER TWO

REVIEW OF LITERATURE ON CLINICAL INSTRUCTION PRACTICE OF NURSE EDUCATORS AND PROBLEMS THEREOF

2.1 INTRODUCTION

This chapter presents a review of literature related to clinical instruction practice of nurse educators. The purpose of literature review in this study was firstly to examine previous research studies and professional journal articles published in South Africa and internationally in order to gather a wide range of information, opinions and comments on the clinical instruction practice of nurse educators and the problems thereof. Relevant books, theses and dissertations were also explored. Secondly, preliminary literature review was done to assist the researcher in deciding on appropriate techniques to be followed during the actual conduct of the study (Comarck 1984:16).

Literature related to clinical instruction was retrieved from computer subject search in SABINET conducted at the Universities of Natal and Zululand libraries. Other lists of source related to the topic were obtained from the University of Zululand library using the card catalogue and the computer-based catalogue. The key words used were:-

clinical instruction; clinical teaching; clinical experience; nursing

education;

ward based teaching; student accompaniment; socialization of student nurses and experiential learning.

2.2 THE MEANING OF "CLINICAL INSTRUCTION PRACTICE"

Clinical instruction practice refers to the totality of directed activity in which student nurses engage in nursing practice with clinical teachers and the consumers of the health service to meet their health care needs (Haukenes and Mundt, (1983) as quoted by Bourbonnais & Higuchi 1995: 37).

According to Van Hoozer, Bratton, Ostmoe, Weinholtz, Craft, Albanese and Gjerde (1987:175) clinical instruction is an interaction between students, clients and other health professionals in settings where people are in need of health care to promote both the maximum learning of students and the maximum health of clients.

South African Nursing Council (1994:4) refers to clinical instruction as practice-oriented teaching given to students in the clinical laboratory situation. It occurs in the presence of a triad, namely, the student, clinical instructor and the patient.

Gunter (1980) as quoted by Mchunu (1997:10) defines clinical instruction as part of teaching that is concerned with imparting knowledge and information. Mchunu (1997:10) views clinical teaching as an activity that promotes learning of students in the clinical area. Such activities may be cognitively, affectively and psychomotor oriented. In this manner student nurses learn to make decisions pertaining to patient care as they mature to become professionals.

In this study clinical instruction and clinical teaching will be used interchangeably to mean the same thing.

2.3 GOALS OF CLINICAL INSTRUCTION PRACTICE IN NURSES EDUCATIONAL PROGRAMME

The first goal of clinical instruction is to provide opportunities in the real work setting that permit the student nurse to develop knowledge, skill and attitudes necessary for efficient client/ patient care. The second goal of clinical instruction is to offer the student nurse the opportunity to apply the knowledge acquired in the classroom and to practise the art of caring. Thirdly, it is an educational strategy for fostering the personal and professional development of the student nurse in a manner that will enable him/ her to be concerned about the health needs of man as a unique human being within his cultural and his total health status (Bourbonnais & Higuchi 1995:37).

In the South African context clinical instruction is related to the total curriculum and not only to the needs and clinical experiences found in a particular unit. The selection of appropriate clinical learning opportunities for student nurses is acknowledged as a crucial element in the clinical education programme. Student nurses are assigned to specific nursing units to enable them to relate the sciences basic to nursing to a particular clinical situation. It is for this reason that the South African Nursing Council prescribes minimum requirements for clinical experience in specified areas. Its aim is not to get the job done, but to draw together all the threads from the physical, biological, medical, pharmacological and social sciences and from the legal provisions which support health care. This teaches the student nurse to utilise all this knowledge in the giving of competent, effective and compassionate health care to clients/ patients (Searle et al. 1986: 250; Woodward, 1986:2).

2.4 NURSE EDUCATOR'S OBLIGATION TOWARDS CLINICAL INSTRUCTION

Clinical instruction, also referred to as clinical accompaniment has always been considered an essential part of nurse training for which the nurse educator is responsible. Although this responsibility is shared with unit professional nurses and in some instances with clinical instructors, the nurse educator should be seen taking a leading or active role. The South African Nursing Council, a statutory body that sets minimum requirements for nurse

education has clearly stated in its regulation relating to professional training of nurses in R425 of February (1985:4) as amended that:-

"Clinical teaching is the practice-orientated teaching given to student nurses in laboratory situations, that the process of clinical teaching or accompaniment takes place in conjunction with the direct involvement and physical presence of the tutor supplemented by the availability of guidelines and learning aids". Therefore clinical instruction by nurse educators is a "legal" obligation and not a matter of choice.

Prominent nurse leaders have reiterated the obligatory role of nurse educators towards clinical instruction. Searle et al. (1986:251) contends that the responsibility for clinical instruction is first and foremost the responsibility of nurse educators and to a lesser extent of the head nurse in charge of the nursing unit. In addition Cele (1990:22) asserts that the nurse educator as a teacher of nursing should be an expert in teaching in the clinical setting as well as in the classroom. The nurse-educator is seen as someone with special attributes that would definitely benefit the student because he/ she possesses the following:-

- superior knowledge of pathology and methods of teaching that pathology
- research based clinical knowledge and skills of implementing that knowledge

- wide variety of educational materials which could surely broaden knowledge base of students
- philosophy and theories of nursing that could shape nursing practice for the better.

Mashaba & Brink (1994:44) are of the opinion that the goal of a nurses educational preparation is that of producing a competent nurse practitioner by using two strands, namely, theory and practice. One cannot produce a competent theoretical nurse at one time and a practical nurse at another time. They view the responsibility of a nurse educator as that of assisting the student nurse to integrate knowledge from other subjects thereby enabling him/ her to realise the value of studying these subjects in relation to his goal of competent nursing intervention. Therefore nurse educators cannot shirk their responsibility or obligation towards clinical instruction.

2.5 THE SCOPE AND CONTENT OF THE CLINICAL RESPONSIBILITY OF NURSE EDUCATOR

As stated in the foregoing discussion, clinical instruction has been the responsibility of clinical instructors and unit professional nurses. Some nurse authors still view unit professional nurses as major contributors in clinical teaching. For instance, Mellish & Brink (1990:218) state that a great deal of clinical instruction, formal and informal, rests in the hands of the unit

professional nurse. They further assert that this fundamental aspect of the work of the professional nurse in charge of the unit has never been taken away from her, nor should it ever be. Ogier (1980) & Fretwell (1982) as quoted by Cele (1990:18) endorse this sentiment by stating that the unit professional nurse is universally recognised as a figure of crucial importance for student learning. However developments and advancements in the education and training of nurses shows a clear evidence that whether in direct teaching or facilitation for teaching, unit professional nurses fall short of expectations (Cele 1990:19). The emphasis of universities on the correlation of theory with practice changed the perception of clinical teaching in nursing education from apprenticeship, under the supervision of a unit professional nurse, to a learning experience directed by a qualified faculty member or nurse educator. The role of the unit professional nurse has become supplementary in nature as he/ she is expected to subsequently supervise and correct the student nurse until he or she becomes proficient. Cele (1990) and Clifford (1993) as quoted by Mashaba & Brink (1994:51) found in their studies that nurse-educators perceived their clinical activities to be either student-related or clinical staff related. Student-related activities included:

- student accompaniment
- demonstrating nursing skills
- formulating clinical objectives

- role modelling professional conduct
- finding problems and looking for areas of concern
- supportive role for students
- assessment and evaluation of students

Clinical staff related activities on the other hand included:

- inservice education of staff
- chatting to unit professional nurses on organisational development
- professional development of unit personnel
- liaising with personnel in the units
- making oneself available in case new personnel wish to discuss issues
- talking to unit personnel and helping them gain self esteem.

2.6 EXPECTED ROLE OF NURSE EDUCATOR IN CLINICAL INSTRUCTION

Selecting clinical learning experiences

The process of selecting clinical learning experiences warrants the consideration of the educational institutions' curricular goals, learning environments which are best able to meet these goals and the clinical expertise of the teacher. These factors influence each other and they are interrelated.

Curricular goals

Clinical experiences which are consistent with the educational institution's beliefs about the nature of nursing and nursing practice should be chosen. For instance one of the major goals of a comprehensive four year diploma course curriculum is the development of decision-making skills in its students; the development of a scientific basis for nursing care and the development of caring behaviours (Bourbonnais & Higuchi 1995:37).

Evolving from the curricular goals should be the clinical objectives which reflect the expected student nurses behaviour desired at the conclusion of the clinical course. According to (Guineé 1966:79; Carpenito & Deuspohl 1985: 105) these clinical objectives serve to:-

- define the desired learning outcomes (cognitive, psychomotor, affective skills)
- direct selection of clinical settings
- guide the selection of student's assignments
- organize teaching-learning activities
- measure students level of performance.

In the South African context the curricular objectives for the four year comprehensive diploma course are outlined in the regulation relating to the approval of and the minimum requirements for the education and training of a nurse (general, psychiatric and community) and midwife leading to

registration (R425 of 22 February) as amended. The programme objectives stipulated in this regulation postulate that the curriculum shall provide for personal and professional development of the student so that, on completion of the course of study he/ she:-

- shows respect for the dignity and uniqueness of man in his socio-cultural and religious context and approaches and understands him/ her as a psychological, physical and social being
- is skilled in the diagnosing of individual, family, group and community health problems and in the planning and implementing of therapeutic action and nursing care for the health service consumers at any point along the health/ illness continuum in all stages of the life cycle and evaluation thereof
- is able to direct and control the interaction with health service consumers in such a way that sympathetic and emphatic interaction takes place
- is able to maintain the ethical and moral codes of the profession and practise within the prescriptions of the relevant laws
- is able to collaborate harmoniously within the nursing and multidisciplinary team in terms of the principle of interdependence and co-operation in attaining a common goal
- is able to delineate personal practice according to personal knowledge and skill, practise it independently and accept responsibility thereof

- is able to evaluate personal practice continuously and accept responsibility for continuing professional and personal development
- evinces an enquiring and scientific approach to the problems of practise and is prepared to initiate and or to accept change
- is able to manage a health service unit effectively
- is able to provide effective clinical training within the health service unit
- is acquainted with the extent and importance of the environmental health services and knows the professional role and responsibilities in respect of the services and in respect of personal professional actions where the services are not available
- is able to promote community involvement at any point along the health/ illness continuum in all stages of the life cycle
- lastly, has the cognitive, psychomotor and affective skills to serve as a basis for effective practice and for continuing education (S.A.N.C. regulation R425 1985: 2) as amended.

Learning environment

In a study conducted by Bourbonnais & Higuchi (1995:39) on selecting clinical learning experiences, the results revealed that the learning environment plays a significant role in ensuring effective clinical teaching. For instance in a curriculum which moves from simple to complex, the

objectives for a clinical course in more senior years would focus on health problems with multiple stressors and the clinical setting should be a large teaching hospital.

A study conducted by Keen & Dear (1983:184) on clinical teaching strategies revealed that the choice of clinical sites is the key to the success of practicum. In preparation for the course, faculty members must develop descriptions of learning opportunities within the various clinical settings. Students should be able to choose settings which would most closely fulfil their own personal objectives in addition to the objectives of the course. They further suggest that the choice of clinical settings as well as the assignment of patients within the clinical setting must be based upon prior clinical experiences offered in the programme, the facilities available, the capabilities of the student, the capabilities of the faculty and the acuteness of the units.

According to Infante (1985:2) the clinical laboratory has had an important place in the history of nursing education and that it is an important part of the total curriculum for the preparation of professional nurse practitioners is undisputed. Learning environment is where the student nurse "learn to give quality nursing care".

The learning environment where clinical instruction could be undertaken

includes hospital units and departments, community health centres, schools, nurseries, day centres, residential homes and industry.

Quinn (1995:182) cited the following as characteristics of a good clinical learning environment:-

A humanist approach to students

Qualified staff should ensure that students are treated with kindness and understanding and should try to show interest in them as people. They should be approachable and helpful to students, provide support as necessary and be very much aware that they are students rather than simply pairs of extra hands.

Team spirit

Qualified staff should work as a team and strive to make the student feel a part of that team. They should create a good atmosphere by their relationships within the team.

Management style

This should be efficient and yet flexible in order to produce good quality care. Teaching should have its place in the over all organization and students should be given responsibility and encouraged to use initiative. Nursing practice should be compatible with that taught in the College of Nursing.

Teaching and learning support

Qualified staff should be willing to act as supervisors, mentors, preceptors, assessors and counsellors. Opportunities should be given to student nurses to ask questions, attend medical staff rounds, observe new procedures and have access to patients/ clients records. Non-nursing professionals such as doctors, physiotherapists, dieticians and chaplains can also contribute to the learning environment provided they are made to feel part of the team. To be effective, the environment should encourage student nurses to take responsibility for their own learning and to actively seek out opportunities for this. Nurse educators and student nurses should work together to examine reasons for failures so as to learn from such mistakes.

It is therefore essential that the nurse educator works in collaboration with the nursing staff in the clinical setting because they play an important role in the selection of clinical learning experiences. They have an in-depth knowledge of patients / clients in the unit environment. Supportive clinical staff can facilitate the process of learning clinical nursing by informing the nurse educator of patient/ client situations that might provide valuable learning experiences.

Instructional process

One of the cardinal roles of the nurse educator is the development of the

instructional process which entails recognizing the goals of the educational program and the learners needs, gathering relevant information about the learners, developing an instructional plan, implementing the plan, evaluating the intervention and making further decisions based on the evaluation data (Van Hoozer et al. 1987: 73).

Assessment

According to Bloom (1976:116) assessment is done to determine if learners possess the necessary prerequisites for accomplishing objectives. It also includes determining the affective characteristics of the learner, "a complex compound of interests, attitudes and self views". Marson (1990) as quoted by Mhlongo (1994:23) further asserts that assessment determines whether student nurses view the clinical experience as relevant to their individual goals. It also identifies differences in rates of learning, cognitive styles and cultural patterns among student nurses relevant to planning the teaching.

Planning

Once the learner's needs have been diagnosed, the second step is formulating the plan of action. Planning means formulating an instructional intervention, a framework or super structure of the instruction. The following should be considered when formulating a plan:-

- the type of the course

- the year or level of training of student nurses
- their prior experience
- the course aims
- the learner objectives
- instructional objectives, and
- evaluation methods to be used during instruction (Van Hoozer et al 1987:73; Quinn 1995: 112).

Implementation

Implementation refers to the actual delivery of instruction. In clinical teaching it refers to assisting the student nurse to integrate theory into practice and to learn the skills of nursing. In order to be able to perform this task, the nurse educator should be clinically competent. Since competence involves the whole person, the competent nurse educator should be highly skilled in all domains namely:-

- cognitive domain dealing with intellectual behaviours that can be attributed to knowledge, comprehension, application, analysis, synthesis and evaluation
- psychomotor domain which emphasizes motor skills characterized by the acquisition and performance of behaviours that involve co-ordinated gross or fine muscle movement patterns
- affective domain which emphasizes feelings and emotions such as

interests, attitudes, appreciations and methods of adjustment.

De Young (1990:7) identified the following behaviours desirable in the nurse-educator to be able to effectively implement clinical instruction:-

- being available in the clinical area and willing to help
- be skilled, experienced and concerned to maintain and improve standards of patient care
- allowing student nurses to recognize and correct errors
- giving verbal encouragement
- showing interest in patients/ clients and their care
- conveying confidence in the learner
- supervising without taking over
- be keen to create a favourable environment for learning
- be alert to the opportunities available for facilitating learning in the clinical situation.

Evaluation

This is the last phase of the instructional process and entails determining whether the student nurse has acquired the necessary clinical competence. The Further Education Curriculum as cited by Quinn (1995:248) define competence as the possession and development of sufficient skills, knowledge, appropriate attitudes and experience for successful performance

in life roles. Evaluation can be summative and formative.

Formative evaluation

It is the ongoing feedback given to the learner throughout the semester. It helps the learner to identify strengths and weaknesses and to meet the objectives of the course effectively. It is therefore diagnostic in nature.

Summative evaluation

Summative evaluation is conducted at the conclusion of certain clinical experiences or the course, to determine if the objectives have been achieved. It provides data for arriving at grades in clinical practice (Reilly & Oermann 1985:101).

Kenworth & Nicklin (1989) as cited by Mchunu (1997:22) states that evaluation is not only the responsibility of nurse educators alone but clinical supervisors and student nurses themselves should be active participants. To the afore-mentioned list of evaluators Mellish & Brink (1990: 229) add unit professional nurses in charge of units, clinical nursing service managers and other professional nurses.

Nurse educator and the need for clinical experience

According to the researchers opinion, clinical teaching entails accompanying the student nurse on the road to professional maturity. Therefore all categories of professional nurses responsible for clinical teaching should be knowledgeable and professionally matured, i.e. they should be experts in the field of nursing. Many nurse researchers share the same view. For instance in a study conducted by Herrmann (1997:317) in which the relationship between graduate preparation and clinical teaching in nursing was explored, she states that the nurse educator's primary goal in the clinical laboratory is to help the student acquire intellectual and psychomotor skills necessary for the practice of nursing. She further asserts that guiding nursing student development in the clinical setting therefore requires in-depth-knowledge of the practice of nursing and the ability to transmit that knowledge to students. In another study conducted by Bourbonnais & Higuchi (1995:39) on selecting clinical learning experience, they state that nurse teachers must have nursing experience relevant to the clinical learning environment selected in order to be able to serve as professional role models. They further state that nurse educators must also possess pedagogical content knowledge and be able to apply this knowledge to the unique demands of the clinical learning environment. In yet another study conducted by Benor & Leviyof (1997:209)

in which student nurses' perceptions of effective teaching was explored, it also became obvious that experience is of fundamental importance in clinical teaching. The results gleaned from this study indicated that student nurses regard nursing competencies as the most important characteristic of a competent nurse educator. This competence according to their view is obtained from experience.

According to Benner & Wrubel, (1982) as quoted by Andrews (1996: 509) experience allows nurses to progress from one level to another. However, it is not to be confused with longevity or simply the passage of time. Experience involves living through actual situations so that they form perceptions and understanding.

2.7 EXPERIENCES GAINED BY STUDENT NURSES IN THE CLINICAL SETTING

Reily & Oermann (1990:14) believe that it is only in the clinical setting that student nurses are socialized into the role of the professional nurse. Part of this socialization into nursing role involves the development of a commitment to be responsible for one's action. It is in the clinical setting that student nurses can witness the results of their actions and where accountability is demanded.

Keen & Dear (1983:183) identified the following experiences gained by student nurses in clinical setting:-

- ability to synthesize knowledge and experience learned in previous courses through multi-disciplinary analysis of clinical, human and organizational forces affecting health care delivery

- clarification and/ or planning of appropriate responses toward the goal of health promotion of groups of clients

- ability to exercise the responsibility and authority required of a professional nurse accountable to a group of clients/ patients and a health care team.

On the other hand Bourbounnais & Higuchi (1995:37) in their study on selecting clinical learning experiences, cited the following experiences gained by student nurses in clinical setting:-

- acquisition of the ability to make decisions in constantly changing patient situations

- ability to organize and manage their time

- ability to set appropriate priorities as well as begin to understand the patient experience.

Andrews (1996:511) contends that clinical rather than the classroom setting is the most effective learning environment for more abstract decision making skills. She further asserts that:

"The skills associated with expert practice and intuitive judgement are best taught in the clinical setting by focusing on the situation as a whole and providing intensive feedback about the accuracy of clinical judgement".

To affirm the above views, Schuster, Fitzgerald, McCarthy & McDougal (1997:154) in their study on clinical nursing education assert that nursing is a practice discipline in which the clinical setting is the primary place where student nurses learn to perform as nurses. They are able to synthesize and apply theories, concepts and principles learned in the classroom and campus nursing laboratories to critical life situations. The same sentiments are shared by Herrmann (1997: 317) in her study on the relationship between graduate preparation and clinical teaching in nursing conducted on a convenience sample of 692 clinical instructors drawn from all National League for Nursing-accredited baccalaureate schools when she states that the primary goal in the clinical laboratory is to help the student acquire intellectual and psychomotor

skills necessary for the practice of nursing.

Many studies conducted by nurse researchers on clinical instruction acknowledge its importance and value in the education and training of student nurses.

Ferguson & Calder (1993:30) conducted a study to identify the value put by nurse educators and preceptors on clinical instruction. Both nurse educators and preceptors were agreeable on the value of clinical instruction in the education programme of student nurses. They cited the following skills acquired by student nurses in the clinical laboratory:-

- ability to collect relevant health data from client and other sources.
- assessment of clients' psychological status
- assessment of the clients' developmental level
- formulation of a plan of care of client based on assessment data
- detect important aspects of clients' behaviour
- convey an attitude of acceptance and empathy toward client.
- act in a non-judgemental manner toward client.

2.8 FACTORS THAT PREVENT NURSE EDUCATORS FROM MEETING THEIR OBLIGATION IN CLINICAL INSTRUCTION

Although clinical instruction is a vital component of student nurses education and training, there is evidence in abundance from both literature and research studies that it is not given the attention it deserves. For instance in a study conducted by Mason & Jinks (1994: 1063) on the role of the practitioner-teacher in nursing, student nurses and auxiliary personnel claimed that clinic instruction is provided on an ad hoc basis. In yet another study conducted by the Department of Health and Social Security in United Kingdom (1972) on 3, 000 trainees regarding the reasons why some hospitals had higher rates of student nurse turnover, many of them expressed dissatisfaction with their own training experiences and wanted to see improvements in the quality of ward-based teaching. Likewise, Birch (1975) in his study of withdrawals from nursing, stated that more than one third of those who left, mentioned lack of ward teaching as a contributory factor (Davis 1983: 91). In a study conducted by Mchunu (1997:54) a certain percentage of them (7,1%) stated that they do not participate at all in clinical instruction. They cited overload with college-related duties as one of the reasons why they do not participate in clinical teaching. The following are reasons gleaned by various authors and researchers as to why clinical instruction is poorly performed:-

Negative attitude

According to literature, some nurse educators have a negative attitude towards bedside work. They tend to relegate clinical teaching to a position of low priority, (Crotty (1993) & Clifford (1993) as quoted by Mashaba & Brink 1994:48). In a study conducted by Paterson (1997: 197) it is revealed that the negative attitude stem from the fact that nurse educators are alienated from unit personnel who have developed a permanent structure that excludes them. Since the separation of nursing education and practice as a reaction to the apprenticeship period of nursing education, nurse educators are regarded as strangers (i.e. a temporary system) in the permanent system in which the student is learning to be a nurse. The nurse educator when in the clinical setting is commonly assigned the status of a "guest" in the house by unit personnel. This situation according to Paterson is straddling the ever-widening gap between the worlds of academia and service. The feeling that clinical instruction is the responsibility of clinical instructors and that it is accorded low status as claimed by nurse educators in a study by Mchunu (1997: 55) could be a source of this negative attitude.

Poor tutor-student ratio

In various research studies, nurse educators have identified the problems of too much college commitments and poor tutor-student ratio as causes of their poor attention to clinical instruction. This is according to studies by

Alexander (1983), Clifford (1993), Alberts (1991) and Cele (1990) as quoted by Mashaba & Brink (1994: 48). Poor tutor-student ratio according to Mashaba & Brink (1994: 48) is a controversial issue because the Van Wyk committee appointed in 1989 to investigate nursing education in South Africa recommended a tutor-student ratio of 1: 10. According to the then South African Nursing Association report (1990) the ratio in most provinces (old order) was less then 1:10 and was as follows:-

Transvaal	1:10, 79
Cape Province	1: 8, 39
Orange Free State	1: 6, 62
Natal	1: 8, 03

If these calculations were correct then, the ratio was reasonable. But recent studies i.e. Cele (1990), Castledine (1994) and Mchunu (1997) do mention overload of work as a factor contributing to poor clinical teaching by nurse educators. Perhaps more studies to determine scientifically the present tutor-student ratios in nursing colleges needs to be undertaken.

Lack of confidence among nurse educators

Guiding nursing student's development in the clinical setting requires in-depth knowledge of the practice of nursing and the ability to transmit that knowledge to students (Herrmann 1997: 317). But contrary to this, nurse

educators claim to have lost contact with reality of nursing care and therefore not confident in practical skills. This has emerged in a study on clinical instruction by Alexander (1982) as cited by Davis (1983: 71) where tutors themselves admitted that they rarely or never taught in the units because of lack of confidence in executing nursing skills. Again Cele (1990) in her study on clinical teaching says she could not help notice feelings of inadequacy in tutors in relation to clinical instruction. The same results were found by Mchunu (1997: 55) where nurse educators mentioned lack of clinical skills and confidence as one of the reasons for not participating in clinical instruction. This lack of clinical competency does not augur well for nurses education and training because clinical teaching is the "heart" of professional education. Nurse educators therefore need to collaborate with the nursing service to ensure clinical competency if they are to teach and produce practitioners who can function in current and future health care system.

Overload of work

The responsibilities of nurse educators are highly diverse. This diversity leads to role overload and role stress. According to Cele (1990) the present system of nursing education introduced in 1986 has compounded the problem. Nurse educators are expected not only to teach in the classroom and clinical setting, but also to carry out the following duties some of which were previously the responsibility of the South African Nursing Council:-

- setting of tests and examination papers
- marking
- prepare memoranda
- counsel students
- give tutorials
- conduct practical examinations
- do research.

This pressure of work has made it impossible for nurse educator to fulfil their clinical teaching role effectively. It is however pleasing to note that Cele (1990: 6) has stated that despite this heavy load of work, nurse educators are making an effort to get involved in clinical teaching to facilitate correlation of theory to practice and to remain credible in the eyes of students.

Poor human relations among staff

Nursing is a practice discipline in which the clinical setting is the primary place where student nurses learn to perform as nurses. For effective teaching and learning to take place in the clinical setting, harmony and good human relations between unit personnel and nurse educators must prevail. However poor human relations between these two major players has been identified as one of the reasons why nurse educators shun going to the clinical areas for clinical teaching and accompaniment.

Paterson (1997) in her study on clinical teaching identified the fact that nurse educators or clinical teachers are alienated from the nurses in the units because the staff has developed a permanent structure that excludes nurse educators from many aspects of nurses' working lives. They (nurse educators) are seen as "strangers" rather than co-workers. The nursing personnel in the units referred to patients as "ours" whilst student nurses referred to as "your students". Almost the same scenario emerged in a study by Cele (1990) where unit professional nurses claimed that tutors keep to themselves when they come to units. Also Infante (1986) states that teachers in nursing are rarely viewed as proper members of the work setting in which they teach and their skills are frequently viewed as pointless. Such comments and attitudes definitely breed bad human relations and this is detrimental to the training of the neophytes of the profession. It is therefore incumbent upon the two parties to work out their differences because a supportive and a conducive clinical environment depends on good relationships established between nurse educators and unit personnel as well as between student nurses and staff (Reilly & Oerman 1985: 81; Paterson 1997: 197; Infante 1986: 177 & Mashaba & Brink 1994: 49).

Educational preparation of nurse teachers

Educational preparation of nurse educators focus mainly on good theoretical teaching in the classroom. This anomaly is evident in literature and research

studies. For instance Mashaba & Brink (1994: 52) state that the root cause of failure nurse educators to play a satisfactory role in clinical instruction lies probably in their educational preparation. They further assert that on paper the course provides for clinical teaching but in practice student nurse teachers are placed in colleges during vacation to gain practice in classroom teaching and nothing is said or done about clinical teaching. The problem in the educational preparation of nurse teachers also emerged in a study by Karuhije (1994) as quoted by Mchunu (1997: 27) where findings revealed a need for change and improvement in the preparation of nurse educators especially in clinical teaching competence. The same findings were gleaned by Herrman (1997: 317) in her study on the relationship between graduate preparation and clinical teaching where respondents stated that there is emphasis on educational theory in the preparation of nurses to teach their profession. This according to Herrmann seems to reflect that knowledge of how to instruct is of less value than that of theory teaching and research. In the light of such socialisation and preparation it becomes impossible for a qualified nurse educator to be positive, active and honest in clinical involvement in his or her subsequent practice. The problem, according to the researchers opinion, is compounded by the fact that some professional nurses register and qualify as nurse teachers without being exposed to adequate clinical practise and are therefore probably inexperienced and lack clinical skills and confidence.

2.9 CONCLUSION

The literature reviewed shows that nurse educators are responsible for moulding future professional nurses, and that this moulding includes both theoretical and clinical teaching. However, it is apparent from some research studies and also literature that nurse educators are not able to fulfil the obligation for clinical teaching because they are deflected respectively into administrative and college-based roles.

CHAPTER THREE

3. THEORETICAL FRAMEWORK FOR THE STUDY

3.1 INTRODUCTION

A theoretical framework is defined as a set of logically interrelated statements of significance (concepts, propositions, definitions) that have been derived from scientific data and philosophical beliefs and from which hypotheses can be deduced, tested and verified (Krampitz & Pavlovich 1981: 152).

This study is based on Kolb's theory of experiential learning. The rationale for selecting experiential learning theory is that it describes the construction of abstract representations by individuals which direct subsequent actions in similar situations. Student nurses in the nursing profession share a common need to practise knowledge, gained from classroom lectures and readings (e.g. journals etc.) in actual concrete situations with patients/ clients. This interactive learning process whereby student nurses build and refine their knowledge of the discipline through person-environment interactions is congruent with the cycle of learning described in Kolb's theory (Laschinger 1990: 1985).

3.2 KOLB'S CYCLE OF LEARNING

In Kolb's theory, learning is defined as a process whereby knowledge is created through the transformation of experience. This definition emphasises several critical aspects of the learning process as viewed from the experiential perspective. First the emphasis is on the process of learning as opposed to content or outcomes. Second, knowledge is a transformation process being continuously created and recreated, not an independent entity to be acquired or tansmitted. Third, experience is the core of learning. Kolb's theory explains the process of learning in terms of cycle consisting of four phases which are dynamic. These are:-

Concrete experience (CE) competencies which enable the individuals to become immersed in actual situations.

Reflective observation (R.O.) competencies which allow the individuals to reflect upon the experiences from different perspective.

Abstract conceptualization (AC) competencies which are used to develop symbolic representations or explanations of what has been experienced.

Active experimentation (AE) competencies.

These are employed to test hypotheses derived from the previously developed

theoretical explanations in attempts to solve practical problems.

In Kolb's cycle students are offered an experience, be it an exercise, game, simulation or practical / ward experience.

They are then encouraged to reflect upon that experience. Out of that experience are developed new theories or models (abstract conceptualisation) which are then tested by the application of these theories. For example when learning about oedema, students may be taken to a ward where there are patients presenting with oedema or perhaps also dehydration. Here students can experience what oedema and dehydration look and feel like (concrete experience). This is then followed by the phase of reflective observation where the educator asks guiding questions such as: what do you notice about skin texture? What are the differences in texture between the two? What similarities are there? What do you think causes these differences? Once the students are able to recognise clinical inferences, they are ready for stage three namely abstract conceptualisation. The nurse educator may for example, ask: What might happen to the oedematous leg if it is not properly cared for? How could you prevent this? Why are you saying this? This should encourage students to develop hypotheses about the future course of oedematous and dehydrated tissue (which is known to them). In this case stage four - active experimentation may have to be preceded by active

reading. Students would consult their textbooks to find out more about physiology and pathology and precautionary measures.

Kolb identifies four learning style categories which relate to competencies described in the learning cycle above. These are:-

Divergers

These have strong concrete experience (CE) and reflective observation (RO) skills and prefer concrete, people-oriented learning experiences. They are good at generating ideas and seeing situations from a variety of perspectives.

Assimilators

These have highly developed abstract conceptualisation (AC) and reflective observation (RO) competencies and excel at developing meaningful conceptualization of experiences. Assimilators tend to prefer symbolic thoughtful learning experiences.

Convergers

These have strong abstract conceptualization (AC) and active experimentation (AE) learning skills and are good at testing out theories or ideas in practical situations. They are very capable problem solvers and prefer learning situations which involve search for a single correct answer.

Accommodators

These have highly developed active experimentation (AE) and concrete experience (CE) learning competencies and excel at carrying out plans and seeking out new experiences. These learners are less analytical than others and prefer to trust their instincts in problem solving situations. Their greatest strength lies in doing things. (Laschinger 1990: 986; Mashaba & Brink 1994: 155).

3.3 THE EXPERIENTIAL TAXONOMY

Experiential learning occurs when a person engages in some activity, looks back at the activity critically, abstracts some useful insight from the analysis and put the results to work.

Steinaker & Bell (1979) as cited by Mashaba & Brink (1994: 150) proposed a hierarchy of behaviour which connotes various progressive stages the learner goes through in meeting the goal of learning from experience, which they called the experiential taxonomy.

The hierarchy includes:

Exposure: conscious of an experience

Participation: deciding on the basis of data already received, to take in experience

Identification: Associate or affiliate oneself with experience

Dissemination : Share experience with others.

3.4 CHARACTERISTICS OF EXPERIENTIAL LEARNING

Active involvement of the total person in a situation

According to experiential theorists, (Dewey, Lewin, Piaget, and others) learning takes place through the active involvement of the student in an activity or experience. This is in contrast to traditional teaching and learning strategies which require that the learner remain passive in relation to an active teacher who dispenses knowledge. This active involvement is not confined to only one realm of human functioning, for instance, perceiving, but should combine thinking, feeling, perceiving and behaviour. The learner must actually experience the situation personally and holistically.

A time for reflection must be available

It is acknowledged by experiential learning theorists that experience alone or even only active involvement in a situation is not sufficient to bring about meaningful learning. A time for reflection is a vital process. The learner should be able to integrate new experience with past experience through the process of reflection. Reflection may be an individual act or a shared process. As an individual act, the learner alone integrates new experience with old. As a shared process, group members who shared the same experience attempt to make sense of it through group discussion.

Knowledge to be transformed into usable tool

Experience and reflecting without transforming obtained information into a usable tool seldom brings about meaningful learning. The learner has to analyse the ideas obtained by reflection, come to conclusions and form concepts. The learner needs to identify concepts that can be used to modify existing behaviour or applied to the reality of everyday life and work of the individual or group.

Experiential learning as a student-centered approach

Experiential learning is a student-centered approach and the keystone of humanistic education theory. Rogers as quoted by Mashaba & Brink (1994: 150) assert that the teacher is a fellow explorer in the learning process. His/ her function is to facilitate learning, not to be informer or authority in the interpretation of experiences. For learning to be successful, a supporting, nurturing, understanding as well as a challenging environment is necessary. The needs of the students must be recognised. This includes the students resources and limitations on entering the learning situation, their interests, motivations and readiness to learn.

3.5 APPLICATION OF THE EXPERIENTIAL LEARNING THEORY TO CLINICAL INSTRUCTION PRACTICE BY NURSE EDUCATORS

Experiential learning is a critical concept in human science theories of learning and because nursing science is a human science, this concept appears particularly relevant for nursing education. It has a specific meaning within human science theories of learning. According to Dewey (1963) as quoted by Mashaba & Brink (1994:150) undergoing an experience or a hands-on approach is not experiential learning. He further cautions that not all experience is equally educational. He provides two criteria to discriminate between educative and miseducative experience, namely, continuity of experience and interaction. Thus meaningful educational experience is one through which the knowledge and skills gained can be effective in managing comparable situations which follow. Meaningful experiential learning goes beyond the immediate experience in that it follows a systematic sequence of activities beyond the experience and suggest an integrative perspective on learning that combines experience, perception, cognition and behaviour. In a miseducative experience there is no continuity of experience and interaction.

Nurse educators therefore need to anticipate potential learning opportunities, recognise unanticipated learning situations when they arise and design instruction that amplifies the positive learning events critically

important to student nurses, professional development. They need also to identify client/ patient populations for learning experiences, find space for clinical conferences, determine objectives for clinical experiences, diagnose individual student nurse's learning needs, plan clinical rotations and schedule, provide for student nurses orientation, select learning experiences, demonstrate professional skills and evaluate learning experiences. All these demanding tasks require a nurse-educator who possess reasonable experience both as nurse-practitioner and educator (Van Hoozer; et. al 1987: 174).

Reilly & Oerman (1985: 36) point out that experiential learning is essential in providing clinical instruction for student nurses because it provides opportunities for problem-solving practice with real clients/ patients, hands-on experience in ministrations of care and moral or ethical decision making relative to clients/ patients, setting or self.

3.5.1 PLANNING AND IMPLEMENTING EXPERIENTIAL LEARNING IN CLINICAL INSTRUCTION

The learning environment

The learning climate that is, both laboratory or clinical practice setting should be such that it supports the activities of the learner. Consideration is given to providing sufficient time for problem-solving and the carrying out of nursing ministrations, supporting creative proposals made by the learner and accepting

the potential of mistakes as an inherent part of any learning experience. In addition, the environment must be characterized by a climate of trust and a caring relationship between nurse educators and student nurses. The nurse educator must be a facilitator of learning, that is, he/ she must make available opportunities for learning and encourage growth by graded responsibility until the student nurse reaches professional responsibility.

Preparing student nurses for experience

It is the responsibility of the nurse educator in any structured or focused learning experience to inform learners what to expect or what is expected from them and what they need to focus on. Therefore formulation of achievable clinical objectives is the core of clinical teaching. Nurse educators usually determine aims and objectives for new student nurses. However, as they become experienced, they are involved in the setting of objectives. These objectives should include the three levels or domains as classified by Bloom and associates, (Van Hoozer et al. 1987:21) namely, cognitive, psychomotor and effective. This is also stipulated by the S.A. N.C. regulation (R425 of February 1985:2) as amended, that cognitive, psychomotor and affective skills be taught to students when introducing them to nursing science. These domains proceed from simple to complex, requiring learners to exhibit a pre-requisite behaviour before proceeding upwards.

Levels of objectives to be achieved by students in clinical practice

Psychomotor level/ domain

This domain, developed by (Simpson & Harron 1972) emphasizes motor skills. It includes concomitant cognitive and affective elements but the demonstration of a motor skill characterised by the acquisition and performance of behaviours that involve coordinated gross or fine muscle movement patterns is the dominant aspect of the response. It consists of the following levels:-

Level 1: Perception, this is the basic level concerned with sensory awareness of stimuli and determination of meaning.

Level 2: Set, this is concerned with mental, physical and emotional readiness to perform a task.

Level 3 : Guided response, these objectives refer to the early stages in skills acquisition where skills are performed through imitation or trial and error.

Level 4: Mechanism, at this level, the performance has become habitual but the movements are not so complex as the next higher level.

Level 5 : Complex overt response, this level typifies the skilled performance, and involves economy of effort, smoothness of action, accuracy and efficiency.

Level 6: Adaptation, here the skills are internalized to such an extent that the student nurse can adapt them to cater for special circumstances.

Level 7 : Origination, this is the highest level and concerns the origination of new movement patterns to suit particular circumstances (Quinn 1995: 279; Van Hoozer et al 1987: 221).

Cognitive level / domain

This level deals with the acquisition of knowledge and intellectual activity. It consists of six sub-levels namely:-

Level 1 : Knowledge, this is the most basic level and all that is required is the bringing up to mind of facts or terminology.

Level 2: Comprehension, this refers to understanding, which is demonstrated by the learner making limited use of information. It includes translation and interpretation.

Level 3: Applicationm, here the learner is required to apply rules, principles, concepts to real situations.

Level 4 : Analysis, this involves the ability to breakdown information into its component parts, which may be elements of information, relationships

between elements or organization and structure of information. Its purpose is to separate the important aspects of information from the less important, thus clarifying the meaning.

Level 5: Synthesis, at this level the learner is required to combine various parts into a new kind of whole. Creativity is present because the learner produces something unique such as a plan or design.

Level 6: Evaluation, this implies the ability to make judgements regarding the value of material and involves the use of criteria (Quinn 1995: 277; Van Hoozer et al 1987: 219).

Affective level/ domain

This domain has particular significance for nursing because it deals with the realm of feelings and attitudes which constitute the caring functions. According to Quinn (1995: 278) many nursing colleges have stated comprehensive behavioural objectives for the cognitive and psychomotor domain but seldom make a coverage of the affective domain. The reason being that "attitudes" and "feelings" cannot be observed directly but are inferred from the person's own account or their behaviour. This domain has five sub-levels:

Level 1 : Receiving or attending. The learner is sensitive to the existence of something and progress from awareness to controlled or selected attention.

Level 2: Responding. This is concerned with active response by the learner, although commitment is not yet demonstrated.

Level 3: Valuing. At this level, the learner appreciates and exhibits commitment, there is internalization of values and attitudes.

Level 4 : Organisation. Having internalized the values, the learner will encounter situations in which more than one value is relevant. The learner at this level demonstrates the ability to organize values and to arrange them in appropriate order.

Level 5: Characterization. This is the highest level where the learner has internalized the value system which becomes his or her philosophy of life. These values characterize an individual (Quinn 1995: 278; Van Hoozer et al. 1987: 220; Mellish & Brink 1990: 33).

Selecting the experience

An experience is defined by Miles (1987: 85) as any activity which generates information. This activity can take place in the clinical situation in the form of interaction (between nurse educators - clients - students), a presentation, a field trip, and observation, demonstration, to name but a few. The nurse

educator in his/ her endeavours to teach nursing skills must recognise and utilize these opportunities according to the student nurses' level of training. For instance when teaching interpersonal skills, the activity to be reflected upon and analysed could be an actual social encounter, a film or a video-tape recording of a nurse-patient or tutor-patient interaction. To learn aspects of clinical care, experience could be arranged in the clinical setting and if the focus is on some clinical skills, experience could be in the laboratory. The nurse educator must however appreciate that experience alone is not enough. The whole experiential cycle must be completed for effective learning to occur. Exposure to the selected experience must be followed by a systematic process of reflection (Mashaba & Brink 1994: 159).

Reflecting on experience

During this phase, student nurses make a systematic examination of their experience and personalise what was learned by applying it to real life situations. The nurse educator during this phase must guide and support student nurses in critically analysing and reconstructing their experience by asking reflective questions and transforming ideas, knowledge and strategies into a familiar word picture appropriate for the content and that particular student nurse. Reflection should take place immediately after experience, either within a group context or in a one-on-one situation. Within a group context, individuals who have participated in the experience share with

colleagues what they saw and felt during the activity. During this activity the nurse educator acts as a facilitator and guides the flow of discussion by asking questions that encourage learners to express their thoughts and feelings.

Abstracting concepts, generalisations and principles

Following the phase of reflection, student nurses need to identify what can be abstracted from the reality of their experience and applied to the reality of their experience as well as to the reality of everyday life and work. From their observations, they may have identified resources and constraints in a situation and have made suggestions regarding how to cope with or turn the constraints to advantage. For instance, after being exposed to a series of insets on communication between nurses and patients, the nurse educator could direct questions on effective communication or a breakdown thereof.

Active experimentation

In this phase, student nurses implement the action plan designed during previous phases and tests the concepts, generalisations and principles abstracted and provide further concrete experiences which will require further reflection thereby continuing the cycle (Mashaba & Brink 1994: 159; Laschinger 1990: 991).

3.6 CONCLUSION

This chapter dealt with learning described by Kolb as the core process of human development and this development results from learning gained through experience. Experiential learning is learning by doing rather than by listening to other people or reading about it.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 INTRODUCTION

In this chapter the research design, target population, sample, research instrument, method of data collection and the plan for analysis of data will be discussed.

4.2 THE RESEARCH DESIGN

The research design used to solicit information from the population under study regarding their clinical instruction practice and problems thereof was a descriptive survey. Goode & Scates (1954) as quoted by Brink (1984:42) states that a descriptive survey is directed toward ascertaining the prevailing conditions (the facts that prevail in a group of cases chosen for the study). According to Polit & Hungler (1995: 187), the term survey can be used to designate any research activity in which the investigation gathers data from a portion of a population for the purpose of examining the characteristics, opinions and intentions of that population. It also focuses on what people do.

This method is essentially a technique of quantitative description for the

general characteristics of the group. This approach to problem solving seeks to answer questions as to the real facts relating to existing conditions.

The advantage of a descriptive survey is that it accurately identifies the characteristics of an individual, a situation or a group. It also examines the frequency with which an event occurs or is associated with another event.

4.3 HYPOTHESIS

As this was a descriptive study it was not necessary to formulate a hypothesis (Polit & Hungler, 1995:51). According to Treece & Treece (1986); Waltz & Bausel (1981) and Sweeny and Olivieri (1981) as quoted by Brink (1984: 42) a descriptive survey can proceed without a hypothesis. Research questions and objectives can be used to guide the study. The study in turn can be used to raise questions and to formulate questions for future studies. The researcher has therefore used objectives to guide this study.

4.4 POPULATION AND SAMPLE

The study focused on nurse educators currently involved in the education of student nurses undergoing the basic nursing course, namely, the comprehensive four year diploma course offered in terms of the South African Nursing Council regulation (R425 of 22 February 1985) as amended, and the bridging course offered in terms of regulation (R683 of 14 April 1989) as

amended. The nursing colleges targeted are located in regions H; D and G namely:-

- Ngwelezane Nursing College (H)
- Benedictine Nursing College (D)
- Charles Johnson Nursing College (G)

(See figure 1.1)

In order to ensure that the sample was representative, the researcher sought to obtain information from the entire population. According to Polit & Hungler (1995: 100) a sample can only be regarded as truly representative of a particular population if all members of that population have a chance of being included in the sample. The list of nurse educators available from each institution under survey was obtained from heads of each institution. Table 4.1 below shows the number of nurse educators in each institution and the number of those who participated in the study. Those willing to participate completed the questionnaires as was indicated in the covering letter.

TABLE 4.1:- NUMBER OF NURSE EDUCATORS AVAILABLE IN EACH INSTITUTION AND THOSE WHO RESPONDED N = 40

INSTITUTION	NUMBER OF NURSE EDUCATORS	NUMBER OF RESPONDENTS
Nursing College D	12	05
Nursing College G	21	20
Nursing College H	20	15 (+3 pilot)
Total	53	40

Forty (40) out of fifty three nurse educators completed the questionnaire making a response of 75.5%. Three nurse educators were excluded from the main study as they had participated in the pilot study.

The researcher targeted Ngwelezane Nursing College and its satellite campuses because it has entered into an agreement of association with the University of Zululand where the researcher is currently employed. According to the National Health Policy Council (NHPC) on the college system, the university with which the college is affiliated is responsible for supervising educational standards of that particular college or group of colleges. This excludes the bridging course, which is still the responsibility of the South African Nursing Council. The researcher therefore deemed it fit to study these colleges to ascertain the extent of involvement of nurse

educators in teaching the clinical dimension of nurses education and training.

4.5 SAMPLING METHOD

The sampling method chosen for this study was the convenience sample which permits the use of the most readily available or most convenient group of subjects, Pilot & Hungler (1987) as quoted by Mhlongo (1984: 39). The purpose was to take all nurse educators working in nursing colleges located in regions D, G and H in order to get total representativeness.

4.6 THE RESEARCH INSTRUMENT

Data was obtained from respondents through questionnaires. The first questionnaire was developed under the direction and guidance of the initial supervisor. However, when the present supervisor took over, some changes in the design of the questionnaire were made. In section A rephrasing of question items on the nursing education information of respondents was made. In Section B item questions received major changes in design but not so much in content except addition of items in the planning aspect of nurse educators for clinical instruction. The new format of the questionnaire included what nurse educators view as ideal regarding their role in clinical instruction (ideal situation) and what they actually do to fulfil their clinical instruction role (actual situation). This format was based on the design by Brink (1984) but used question items of the first questionnaire.

4.6.1 Design of the questionnaire

The questionnaire was divided into two sections: Section A consisted of Biographical, Educational and Professional data. Section B contained items on the views of nurse educators regarding their role as clinical instructors and their involvement in clinical instruction. This aspect was divided into the following subsections:-

- nurse educator as the facilitator of learning in the clinical area
- motivation and support provided by nurse educators to student nurses while in the clinical area
- exploration of what nurse educators think ought to be done by them in the clinical area (ideal) and how much they afford to do (actual) using the teaching/ learning and or instructional process
- problems and constraints they encounter during clinical instruction and suggested solutions to overcome the problems.

4.6.2 Format of questions

The questionnaire consisted of both closed and open-ended questions. In section B statements were formulated instead of questions and a double-barrelled Likert-type scale was designed. Each statement describing the ideal activities of nurse educators used a five-point scale, namely strongly disagree, disagree, uncertain, agree and strongly agree. In the actual activities a five-point rating scale consisting of not at all, minimal, reasonable, considerable

and a great deal was designed. A key was included to guide and direct respondents. The last question in section B on problems and constraints was open-ended.

4.7 PRE-TESTING THE QUESTIONNAIRE

The questionnaire was pre-tested on a sample consisting of three nurse-educators from Ngwelezane Nursing College. The names of all nurse-educators were listed on paper and the researcher selected every fifth name on the list until three nurse educators needed for the pilot studies were obtained. The aim of pre-testing the questionnaire was to eliminate ambiguous or unclear questions, change phrasing where necessary and eliminate any confusing statements and instructions. The subjects were specifically requested to identify irrelevant questions and to examine the format, style and language clarity. Time taken by respondents ranged from 25-30 minutes. The respondents found the content relevant, the length of questionnaire reasonable and no item was regarded as unsuitable or needed discarding. These nurse educators were excluded from the main study.

4.8 VALIDITY AND RELIABILITY

Validity refers to the degree to which an instrument measures what it is supposed to measure. Reliability on the other hand refers to the accuracy and consistency of an instrument (Polit and Hungler 1995:347). The reliability and

validity of an instrument are not totally independent qualities of an instrument. A measuring device that is unreliable cannot possibly be valid. The two are therefore important features of any instrument including a questionnaire.

The pre-testing of the instrument was therefore specifically aimed at ensuring that the item questions would enable the researcher to meet the objectives of the study, namely, to measure the clinical instruction practice of nurse educators and problems thereof.

4.9 DATA COLLECTION

4.9.1 Ethical consideration

When humans are used as subjects in scientific investigations great care must be exercised in ensuring that the rights of those humans are protected (Polit & Hungler 1995: 119). To meet this obligation, the researcher completed a prescribed form requesting permission from head office KwaZulu-Natal Department of Health to conduct research at Ngwelezane Nursing College and its satellite campuses. This was approved by both head office personnel and Regional Medical Superintendent of Ngwelezane Health ward. Subsequent to this approval permission was also granted by Medical Superintendents of satellite campuses. Letters requesting permission to conduct the study were also written to principals of the three nursing colleges (see annexure 1).

The covering letter requesting prospective respondents' participation was attached to the questionnaire. Respondents were requested not to write their names or names of the institutions on the questionnaire to ensure confidentiality and anonymity.

4.9.2 Data collection procedure

The researcher arranged meetings with the principals of campuses under study to explain the nature of the project to prospective respondents and at the same time collect data. At institution H respondents completed questionnaires in their offices while the researcher waited in the principal's office. Some of the respondents could not complete the questionnaires because of college based commitments. The questionnaires were left with them to be completed later and were to be submitted to the principal for collection by the researcher. Two respondents failed to return the questionnaires despite several visits and telephone reminders by the researcher.

The second round of questionnaire distribution was done at institution G. Nurse educators were requested by the principal to assemble in a lecture hall and after briefing by the researcher, they completed the questionnaires. The response rate was good.

The final round of questionnaire distribution was done at institution D. The

response rate here was poor despite a second visit by the researcher and several telephonic reminders (see table 4.1 above).

Most respondents took about 30 - 35 minutes to complete the questionnaires. The response rate was satisfactory because questionnaires were completed by forty nurse educators out of fifty three making a response rate of 75.5%.

TABLE 4.2 RESPONSES TO DISTRIBUTED QUESTIONNAIRES

DESCRIPTION	NUMBER	PERCENTAGE
Questionnaires distributed	53	100
Questionnaires returned	40	75.5
Questionnaires not returned	13	24.5
Usable questionnaires	40	100
Unusable questionnaires	00	00

4.10 CODING AND PLAN FOR ANALYSIS OF DATA

The researcher edited each questionnaire and thereafter they were coded with the assistance of a statistician. The coded data was put into the computer using Statistical Analysis Programme (SAP). Data was presented in the form of tables and bar graphs in chapter 5.

The open-ended questions were manually analysed and presented in the form

of a table.

4.11 CONCLUSION

This chapter dealt with research methodology which basically includes the research design, development of the research instrument, data collection, response rate by respondents and plan for data analysis.

CHAPTER FIVE

DATA ANALYSIS, PRESENTATION AND DISCUSSION OF FINDINGS

5.1 INTRODUCTION

The information presented in this chapter was obtained from questionnaires completed by nurse educators of Regions D, G and H as described in the sample in chapter 4. Analysis of open-ended questions was done manually and closed-ended questions were analysed by means of statical analysis programme (SAP). The data will be presented in the form of tables, pies and bar graphs.

SECTION A

5.2 BIOGRAPHICAL DATA

The researcher deemed it necessary to include biographical data of respondents although it was not part of objectives of this study. The reason was that variables such as sex and age might have an influence on the role of nurse educators in clinical instruction practice. This is confirmed by Polit & Hungler (1995:292) who states that the reason for collecting biographic data is that personal characteristics have time and again shown relation to a person's behaviour and attitudes in a given situation.

5.2.1 Gender

TABLE 5.1:- GENDER DISTRIBUTION OF NURSE EDUCATORS

N = 40

GENDER	FREQUENCY	PERCENTAGE
Male	01	02.5
Female	39	97.5
Total	40	100

Table 5.1 depicts that out of forty nurse educators who participated in the study, only one (2.5%) was a male. This confirms the generally held view that nursing is a female dominated profession. For example, in a study conducted by Brink (1984: 124) on the registered nurse tutor in the Republic of South Africa, females dominated the sample. Out of two hundred and thirty three (233) respondents, two hundred and twenty (220) were females and only thirteen (13) were males. However, there has been an improvement over the past few years in the training of males as is indicated in a study conducted by Gumbi (1987: 198) where-in she discovered that about three percent (3%) males were trained as registered nurses in the KwaZulu region alone in 1987. Despite this improvement the number of males in the nursing profession remains low. For instance in a study conducted by Mhlongo (1994: 47) on the role of the unit sister in clinical teaching thirty (83.3%) out of thirty six respondents were females and only six were males. In yet another study

conducted by Mchunu (1997:46) on the nurse educators' perception of their clinical instruction role sixty five (92%) out of seventy respondents were females and five (7.1%) males. The trend observed by the researcher is that most males on completion of training prefer to work either in industries or psychiatric institutions. The sample was therefore biased in favour of females.

5.2.2 Age distribution

TABLE 5.2:- AGE DISTRIBUTION OF NURSE EDUCATORS

N = 40

AGE GROUP IN YEARS	FREQUENCY	PERCENTAGE
20 - 29	03	07.5
30 - 39	21	52.5
40 - 49	14	35
50 - 59	02	05
Total	40	100

Table 5.2 indicates that the majority of nurse educators were in the middle ages with ages 30 - 39 years ranking the highest (52.5%) followed by 40 - 49 years with 35%. It is therefore assumed that they possess adequate experience as nurses and mature enough both personally and professionally to be able to impart knowledge and skills to student nurses in the clinical setting. They are also probably in a position to act as effective polestars for

student nurses. Leddy (1985) as quoted by Xulu (1988: 86) describes a polestar as a figure who exerts a forward pull, offers guiding principles and has a major impact on the road the child takes.

5.3 NURSING EDUCATION INFORMATION

5.3.1 Type of basic nursing programme completed by the respondents

TABLE 5.3:- BASIC NURSING PROGRAMME COMPLETED BY THE RESPONDENTS N = 40

NURSING PROGRAMME COMPLETED	FREQUENCY	PERCENTAGE
SANC 3yr diploma	17	42.5
University bachelors degree	19	47.5
Integrated four year diploma	04	10
Total	40	100

Table 5.3 above depicts that nineteen respondents (47.5%) completed the University Baccalaureate (B Cur) programme. Seventeen respondents (42.5%) have undergone the phased out three year diploma course offered by the then South African Nursing Council. Four respondents (10%) completed the four year comprehensive diploma course offered at nursing colleges. The high percentage of nurse educators holding a University Bachelors degree is not surprising. In 1986, professional nurse training in South Africa became

part of the main stream of the general education system of the country following the promulgation of Regulation 425 of February 1985 (as amended) by the South African Nursing Council. According to this regulation, professional nurse training was henceforth to be offered by Universities with Nursing Science Departments and Nursing Colleges that have an agreement of association with universities. The new programme leads to registration as a nurse (general, psychiatric, community) and midwife.

The researcher presumes that respondents who have done a bachelors degree and a four year comprehensive diploma course might experience some problems in executing clinical teaching because of their limited exposure to clinical areas. During training they are allocated to the wards for short periods of time and spend most of it in classrooms for theory. They therefore appear to lack clinical skills and this could negatively affect their clinical instruction practice as nurse educators. Their lack of clinical skills was observed by the researcher while working with some of them in a hospital setting. The researcher's observations are confirmed by a study conducted by Ntombela, Mzimela, Mhlongo and Mashaba (1996: 17) on the clinical performance of nurses who recently completed the comprehensive basic nursing courses where their performance was viewed or rated as predominantly poor. Such nurse educators would encounter problems in teaching and guiding student nurses in the clinical setting because they lack clinical skills.

On the other hand respondents who have undergone the South African Nursing Council diploma course probably possess more clinical skills and experience than their counterparts (bachelors degree and comprehensive diploma). During their training they spent most of the time in the clinical areas, making them skilled and experts in clinical nursing. They are therefore expected to be good and committed clinical teachers of nursing.

5.3.2 Programme completed by respondents at registration as nurse educator with the South African Nursing Council

TABLE 5.4:- PROGRAMME COMPLETED AT REGISTRATION AS NURSE EDUCATOR WITH THE SOUTH AFRICAN NURSING COUNCIL N = 40

PROGRAMME COMPLETED AT REGISTRATION AS A NURSE EDUCATOR	FREQUENCY	PERCENTAGE
University diploma	13	32.5
Post registration bachelors degree	25	62.5
South African Nursing Council diploma	02	05
Total	40	100

Table 5.4 above indicates the distribution of the total study group according to the type of nurse educator programme completed by respondents. Twenty five (62.5%) out of forty completed the post registration bachelors degree and

only two (5%) completed the South African Nursing Council two year diploma course leading to registration as a nurse educator. Thirteen respondents (32.5%) completed the University diploma in nursing education.

The increase in the number of University trained nurse educators has been brought about by the introduction of distance education through universities such as UNISA. This expanding pool of nurse educators with University degrees is pleasing because they probably possess a broader scientific knowledge, not only in the field of nursing but also in general. Over and above they possess good clinical skills because they had done their studies while working in the clinical settings. They are therefore assumed to be skilled in nursing practice and this might have a direct influence in their clinical teaching role - they are expected to be good if not better clinical teachers.

5.3.3 Present highest professional qualifications

TABLE 5.5: PRESENT HIGHEST QUALIFICATIONS OF NURSE EDUCATORS

N = 40

QUALIFICATION	FREQUENCY	PERCENTAGE
Bachelors degree	20	50
Honours degree	16	40
Post registration diploma	02	05
Masters degree	02	05
Total	40	100

As depicted in table 5.5, twenty out of forty nurse educators (50%) held bachelors degree, sixteen (40%) honours degree and only two (5%) post-registration diploma. It was pleasing to observe that the number of respondents with a post-registration university degree is higher than those who did a diploma. One assumed that a nurse educator who has done a degree in nursing education is more knowledgeable than the one who did a diploma. This broad scope of knowledge should enable him/ her to provide adequate guidance of students so that at the end of education and training, the student is a skilled practitioner of nursing. Above all, she is probably in a position to understand that theory and practice are inseparable if nursing education is to

be effective. Therefore she is expected to accept her clinical teaching function. Mashaba & Brink (1994: 44) assert that the nurse educator should be involved in both theoretical and clinical teaching because the goal of nurses' educational preparation is to produce a competent nurse using two strands: theory and practice.

5.3.4 Engagement in formal study beyond the highest degree held

TABLE 5.6: ENGAGEMENT IN FORMAL STUDY BEYOND HIGHEST DEGREE HELD N = 40

ENGAGEMENT IN FORMAL STUDY	FREQUENCY	PERCENTAGE
Engaged	18	45
Not engaged	22	55
Total	40	100

The analysis of nurse educators presently undertaking further studies was included to establish how many registered nurse educators in the sample group had taken advântage of the existing opportunities to further their studies. It is apparent from table 5.6 above that more than half of the sample group (55%) are not engaged in further study. Nevertheless, one should point out

that this slightly higher percentage does not imply that nurse educators are not adequately prepared to train nurses as table 5.5 indicates that they are adequately qualified. It is interesting however to note that 45% of respondents are infact engaged in further studies. This is in accordance with the expectations of the nursing profession as a whole that nurse educators who are entrusted with the task of producing future practitioners of nursing should themselves be qualitatively well prepared (Brink 1984: 136). This will enrich their tutoring skills, broaden their knowledge and expertise necessary for effective guidance of student nurses in their clinical practice.

5.4 PROFESSIONAL INFORMATION

5.4.1 Nursing experience prior to registration as nurse-educators

TABLE 5.7:- NURSING EXPERIENCE OF NURSE EDUCATORS PRIOR TO REGISTRATION AS A NURSE EDUCATOR N = 40

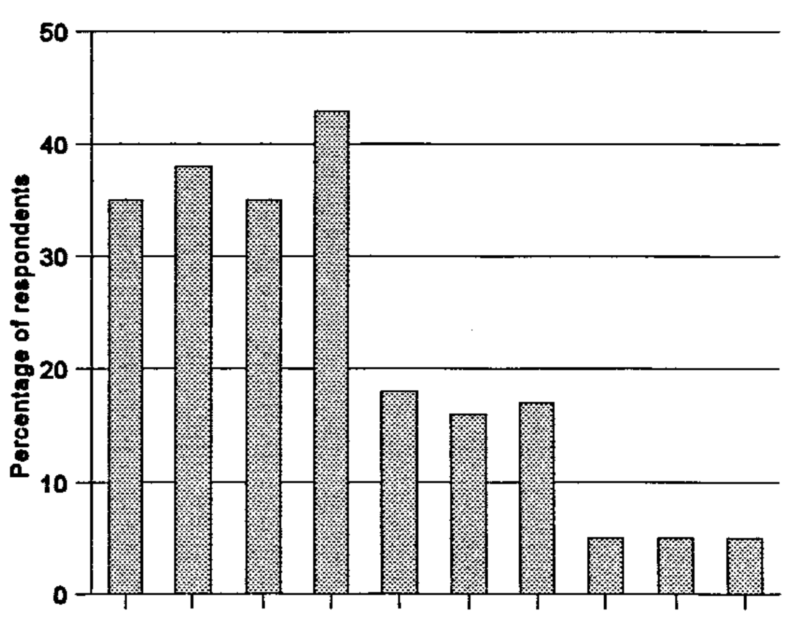
EXPERIENCE AS NURSE IN YEARS	FREQUENCY	PERCENTAGE
1 - 2	07	17.5
3 - 4	04	10
5 and above	29	72.5
Total	40	100

The item of nurse educators' clinical experience was included to establish

those with a limited experience because previously nurse leaders have been very vocal about the need for adequate clinical nursing experience before taking up teaching positions. This is true especially because nursing is a hands-on profession, therefore nurse training requires adequate clinical experience on the part of the educator. Only the teacher with a strong clinical background can determine which clients / patients have conditions, and situations that are appropriate for students' competency levels (Bourbonnais & Higuchi 1995: 39). A minimum of two years clinical experience in an institution approved by the South African Nursing Council had been a prerequisite for nurse-educators' training until 1966. Then on recommendation of the National Health Policy Council, it was assumed that a minimum of three years would be accepted as adequate (Brink 1984:150). Evidence obtained from respondents implies that the majority (72.5%) had adequate experience of clinical nursing to support sound clinical teaching. However, a small percentage (17.5%) seem to be inexperienced to execute the clinical teaching programme effectively and to provide the necessary support and guidance to neophytes.

.4.2 **Field of nursing experience**

FIGURE 5.1: FIELD OF EXPERIENCE WHERE RESPONDENTS OBTAINED SIX MONTHS EXPERIENCE



Med. Surg. Peads Mid C.H. Psych Adm. Opth C.I. I.C.U.

Key:

Med.	-	Medical Nursing	Mid.	-	Midwifery
Surg.	-	Surgical Nursing	C.H.	-	Community Health Nursing
Peads	-	Peadiatric Nursing	Psych.	-	Psychiatric Nursing
Adm.	-	Nursing Administration	C.I.	-	Clinical instruction
I.C.U.	-	Intensive Care Unit			

As shown above, figure 5.1 indicates the field of nursing where respondents obtained at least six months clinical experience before registration as nurse teachers. This item is important because it gives an indication of the common field of expertise of nurse educators who participated in the study. It must be noted however that no one respondent has experience in a single field. The trend is that respondents have been involved in more than two fields. Nonetheless the statistical data collected in this item makes it

possible for the researcher to develop a logical assumption pertaining to the more experienced field. Ranking high in order is midwifery nursing (43%); surgical nursing (38%) and medical as well as paediatric nursing with (35%) respectively. These results are satisfactory because they imply that nurse educators have had reasonable exposure to some fields of nursing. They are therefore expected to effectively implement their clinical instruction practice to the benefit of the student and the profession as a whole. These findings are supported by Herrmann (1997:317) who states that guiding nursing students' development in the clinical setting requires in-depth knowledge of the practice of nursing.

5.4.3 Position held for more than one year before doing nurse educators course

TABLE 5.8:- POSITION HELD FOR MORE THAN ONE YEAR BEFORE DOING THE NURSE EDUCATORS' COURSE.

N = 40

POSITION HELD	FREQUENCY	PERCENTAGE
•Chief professional nurse	02	05
•Senior professional nurse	13	32.5
•Professional nurse	21	52.5
Student nurse	04	10
Total	40	100

The positions which the respondents had held for more than one year before doing the nurse educators' course is depicted in table 5.8. It is interesting to note that fifteen respondents (37.5%) who had already reached the higher echelons in the nursing service still undertook training as nurse educators. Of these, thirteen (32.5%) were senior professional nurses and two (5%) were chief professional nurses. These figures indicate great interest and motivation by respondents to teach. Twenty one respondents (52.5%) the highest percentage, were professional nurses. This group had probably acquired

adequate clinical nursing experience to enable them to produce competent, knowledgeable practitioners of nursing who are capable of exercising educated judgement in the care of patients.

It is however disturbing to note that four respondents (10%) were still student nurses when they registered as nurse educators. This is in direct contrast with the recommendations made by the National Health Policy Council in 1982 which stipulated at least three years experience before becoming a nurse tutor. In the researchers opinion the latter group does not have any experience whatsoever as professional nurses. They are presumably not competent enough to act as role models to guide the learning of students in the clinical setting. Perhaps stringent measures should be put in place to forbid training as a nurse educator immediately after completion of basic nurse training. Such practice creates an impression that although clinical expertise in nursing is commonly accepted as important, in the main it receives less recognition than academic achievements.

SECTION B

5.5 VIEWS OF NURSE DUCATORS REGARDING THEIR ROLE IN CLINICAL INSTRUCTION

This section deals specifically with how nurse ducators under study view their role in clinical instruction. The researcher was of the opinion that nurse educators perception of their clinical dimension would, to a large extent influence the manner in which they execute this important aspect of student nurses educational programme.

5.5.1 Opinions as to whether clinical instruction should be made the responsibility of nurse ducators

TABLE 5.9 : OPINIONS AS TO WHETHER CLINICAL INSTRUCTION SHOULD BE MADE THE RESPONSIBILITY OF NURSE EDUCATORS

N = 40

RESPONSES	FREQUENCY	PERCENTAGE
Yes	29	72.5
No	11	27.5
Total	40	100

As indicated in table 5.9, the majority of respondents (72.5%) were unanimous that clinical instruction should be made the responsibility of nurse

educators. They motivated their answer by giving the following reasons:-

- nurse educators are always updated with changes and developments in the nursing field including clinical practice. It is therefore imperative that they are always present in the clinical sphere of nursing to guide, support and demonstrate to student nurses how a particular nursing skill is performed and how nursing care is provided to the consumer of the service

- to strike a balance between theoretical and practical learning. This is important to ensure that a skilled practitioner of nursing is produced on completion of training

- as secondary rationale, respondents argued that student nurses should be adequately exposed to clinical settings during their education and training. The responsibility for this lies squarely with nurse educators.

Such response is gratifying because it gives an impression that these respondents were probably performing their role as clinical instructors.

However, the same figure (5.3) depicts a small percentage of respondents (27.5%) who were of the opinion that clinical instruction should not be the responsibility of nurse educator. But it is rather pleasing to note that the manner in which their response was qualified indicate that they did not necessarily disagree with the idea outright. Instead they argued that clinical instruction should be a joint responsibility of all levels of professional nursing as it is meant to fuse theory into practice. Nurse educators who viewed clinical instruction as their function further suggested that it must be shared between tutors and clinical instructors. Some even added that ward professional nurses have a teaching function to perform.

Sharing clinical teaching has been suggested by some leading nurse educators including the SANC. For instance, Mellish & Brink (1990: 229) assert that clinical instruction is the responsibility of tutors, unit professional nurses and clinical nursing service managers. The SANC regulation (R753 of 1988) stipulates that the clinical instructor or unit professional nurse should supervise and correct the student until he or she become proficient in a particular skill. In spite of this, Searle et al. (1986: 251) maintains that clinical instruction is primarily the responsibility of tutors and to a lesser extent of

head nurse in charge of the nursing unit. Therefore nurse educators cannot and should not run away from such an important aspect of nurses' education and training. To shirk the responsibility for clinical instruction would have disastrous effects. The student nurses may at the end of training pass the theoretical examinations but prove to be incompetent and unsafe practitioners. The ability of rendering efficient client/ patient care can only be acquired through proper guidance and practical supervision from persons responsible for education and training programmes.

5.5.2 Opinions as to whether clinical instruction should remain the responsibility of clinical instructors as previously done

This item was included to establish the nurse educators opinion regarding the previous practice in clinical instruction where it was made the exlusive responsibility of clinical instructors. They were to state whether this practice was ideal or whether the status quo should remain (responsibility of nurse educators). It was interesting to note that a third dimension was included by respondents, namely, that clinical teaching should be a shared responsibility by nurse educators and unit professional nurses.

TABLE 5.10:- VIEWS WHETHER CLINICAL INSTRUCTION SHOULD REMAIN THE RESPONSIBILITY OF CLINICAL INSTRUCTORS AS PREVIOUSLY DONE

N = 40

RESPONSIBILITY FOR CLINICAL INSTRUCTION	FREQUENCY	PERCENTAGE
Clinical instructors	08	20
Nurse educators	27	67.5
Shared responsibility (nurse educator and unit professional nurses)	05	12.5
Total	40	100

As depicted in table 5.10 above a large percentage of respondents (67.5%) felt that clinical instruction should be the responsibility of nurse educators as it is presently the case. To this view, they added a qualification that clinical instruction being left to nurse educators facilitates a consistent correlation between classroom and the wards.

Twenty percent of respondents felt that the previous practice was ideal (clinical instruction the responsibility of clinical instructors). They argue that nurse educators are overloaded with work pertaining to their teaching

function. This includes preparation for lessons, teaching a number of classes and marking tests and examination papers. Their responsibilities leave them with no time to involve themselves in clinical instruction to any meaningful degree. The sentiment that clinical instruction should be the responsibility of clinical instructors was suggested as one alternative by Xulu (1988: 61) in her study on the professional nurses' opinion regarding the impact of the comprehensive diploma programme of nursing standards wherein she states:-

> "With the introduction of the comprehensive diploma programme, nurse educators are now extensively involved in the marking of a series of semester tests for various subjects, setting of semester examination papers and marking of these. One of the alternatives that may help to rescue this situation is the allocation of permanent clinical instructors who will always be at the student's side in the clinical setting, teaching them and evaluating their performance regularly."

The remaining five respondents (12.5%) felt that clinical teaching should be a shared responsibility between nurse educators and clinical instructors. From these findings it is apparent that a large percentage of nurse educators probably participate in clinical teaching of student nurses because they

acknowledge it as their role.

5.6 EXTENT OF INVOLVEMENT OR PARTICIPATION OF NURSE EDUCATORS IN CLINICAL INSTRUCTION

5.6.1 Participation and non participation in clinical teaching by nurse educators

TABLE 5.11 : PARTICIPATION AND NON PARTICIPATION IN CLINICAL TEACHING BY NURSE EDUCATORS N = 40

RESPONSES	FREQUENCY	PERCENTAGE
Involved	38	95
Not involved	02	05
Total	40	100

In this item respondents were to indicate whether they do or do not participate in the clinical teaching of student nurses. Table 5.11 depicts that thirty eight respondents (95%) do participate in clinical instruction. It was pleasing to note such a large percentage of tutors being committed to the clinical teaching of would-be professional nurses. However, one should point out the remaining 5%, although a very small percentage are doing a disservice to the nursing profession as a whole. One would expect that all nurse educators are

nursing profession as a whole. One would expect that all nurse educators are aware of the need to provide clinical teaching, guidance and support to student nurses in the clinical area.

5.6.2 Reasons for participation in clinical teaching

This item was meant for respondents who indicated that they participate in clinical teaching.

TABLE 5.12:- REASONS FOR PARTICIPATION IN CLINICAL TEACHING N = 38

RESPONSES	FREQUENCY	PERCENTAGE
Part of job description	04	10.5
Necessary for integration of theory into practice	10	26.3
Necessary for development of safe, skilled practitioners	06	15.8
All of the above	10	26.3
To keep up to date with developments in care of patients	06	15.8
Enjoy being with patients and students in the wards	02	05.3
Total	38	100

As illustrated in table 5.12 above, ten respondents (26.3%) indicated that they did clinical teaching to facilitate integration of theory into practice. Another percentage (26.3%) stated that they teach clinical nursing for the following reasons:-

- part of job description
- necessary for integration of theory into practice
- necessary for the development of skilled, safe practitioners of nursing.

Six respondents (15.8%) cited the need for development of safe and skilled practitioners as their sole reason for participating in clinical instruction. Another 6 (15.8%) stated they participate to keep up to date with the developments in the care of patients. Four respondents (10.5%) did it as part of their job description. The remaining two respondents (5.3%) participated because they enjoyed being with patients and student nurses in the wards. Whatever the reason(s) may be it was gratifying that a large percentage of nurse educators (95%) were participating in clinical teaching. This is essential for proper socialization of students into nursing and helping them form attitudes and values in keeping with the ethical and moral standards of the profession (De Young 1990: 19).

5.6.3 Average time spent doing clinical teaching

This item was also meant for nurse educators who participated in clinical teaching.

TABLE 5.13:- TIME SPENT IN CLINICAL TEACHING

N = 38

DURATION/ HOURS PER WEEK	FREQUENCY	PERCENTAGE
1 - 2	16	42.1
3 - 5	14	36.8
6 - 8	03	07.9
8+	05	13.2
Total	38	100

Information obtained from table 5.13 indicates that sixteen respondents (42.1%) spent about 1 - 2 hours per week in the clinical area. Fourteen respondents (36.8%) spent between 3 - 5 hours per week. Five (13.2%) spent more than eight hours per week. Three (7.9%) spent between 6 - 8 hours per week. This indicates a degree of commitment in clinical teaching although the percentage of nurse educators spending more hours in clinical teaching was very small (13.2%). However, there is no stipulated policy concerning the actual number of hours to be spent by nurse educators in the clinical setting. The arrangements are set out by the institutions. For instance Mashaba &

Brink (1994: 50) cited one nursing college which had stipulated in nurse teachers contracts that they should spend ten percent (10%) of their time in clinical teaching. On the other hand Mellish & Brink (1990: 226) are of the view that careful planning by tutors is necessary to enable them to spend time in the units, but that the time will be limited by pressures of their teaching programmes at the college. In a study conducted by Schuster, Fitzgerald, McCarthy & Dougal (1997: 155) on work load issues in clinical nursing education, they cited the American Association of University Professors (1970) which suggested twelve hours as the maximum undergraduate credit hours teaching load for faculty in one term. This translates into twelve face to face contact hours per week. Perhaps leaders in nursing education in our country also need to work out a policy or at least guidelines on the actual number of hours to be spent by nurse educator doing clinical teaching.

5.6.4 Reasons for non participation in clinical teaching

As reflected in figure 5.11 above, only two respondents (5%) indicated non participation in clinical teaching. They were further requested to indicate reasons why they were not participating in teaching clinical nursing. A list of statement was given and they were urged to point out additional reasons in the

space marked "other".

TABLE 5.14: REASONS FOR NOT PARTICIPATING IN CLINICAL TEACHING

N = 2

	1	2	3	4	5
Respondent 1	●	●	●		
Respondent 2	●	●	●		

Key statements

1 = Overloaded with classroom teaching and other college-based duties.

2 = Lack of proficiency in clinical skills.

3 = Feeling that what nurse educators teach in class is removed from clinical reality.

4 = Not the responsibility of nurse educators.

5 = Other

Table 5.14 reflects that the two respondents (5%) who indicated that they were not involved in clinical instruction stated as their rationale that what they teach in class is totally removed from clinical reality. They therefore see no

reason why they should involve themselves in clinical instruction. The other reasons they gave for their non-involvement in clinical teaching were that they are overloaded with classroom teaching and other college based duties. They lacked proficiency in clinical skills.

Perhaps this small percentage of respondents need to re-visit guidelines for the course (that they teach) leading to registration as a nurse (general, psychiatric and community) and midwife (R425 of February 1985) as amended. In this regulation it is stated that student accompaniment is a process that takes place in conjunction with the direct involvement and physical presence of the tutor, supplemented by the availability of guidelines and learning aids. Accompaniment of students include demonstrating and evaluating students performance in the clinical area. Therefore according to this regulation nurse-educators have a responsibility for clinical teaching.

5.6.5 The degree to which nurse educators perceive the ideal clinical instruction practice dimension and the extent to which they are actually involved

This item was included to establish what nurse educators perceive to be the ideal activities that they are to perform when fulfilling their role as clinical instructors, and how much they translate the ideal into actual practice.

Information was elicited through a double-barrel Likert scale consisting of scale 1 for ideal practice and scale 2 for the actual practice. The Likert type questions in the ideal scale were collapsed horizontally into three categories. Responses 1 (strongly disagree) and 2 (disagree) were classified as "disagreeable." Responses 4 (agree) and 5 (strongly agree) were classified as "agreeable" responses. Class three which is "uncertain" was included specifically for those individuals who were not sure whether to agree or disagree. In the actual scale, responses 1 (not at all) and 2 (minimally) were classified as "not involved or "non participatory". Responses 3 (reasonable), 4 (considerable) and 5 (a great deal) were classified as "involved" or "participatory". These two terms namely "involved" and "participatory" were used inter changeably in this research.

The scale had thirty seven (37) statements (four of which had sub-statements) grouped into six sections. The first two sections were on facilitation of clinical teaching, motivation and support provided to student nurses while in the clinical care. The remaining four sections followed the steps of the instructional process, namely assessment, planning, implementation and evaluation.

Respondents had to indicate by means of a cross (X) the extent to which they agree with activities listed on the ideal scale and indicate how much of the ideal activities they manage to translate into practice (actual). Analysed data is presented in the form of tables and bar graphs.

5.6.5.1 Ideal and actual extent of participation of nurse educators in the facilitation of learning in the clinical area

This item aimed at establishing the ideal and actual extent of involvement of nurse educators in creating a supportive and facilitative milieu for student nurses in the clinical area.

TABLE 5.15 NURSE - EDUCATOR AS FACILITATOR OF LEARNING IN THE CLINICAL AREA

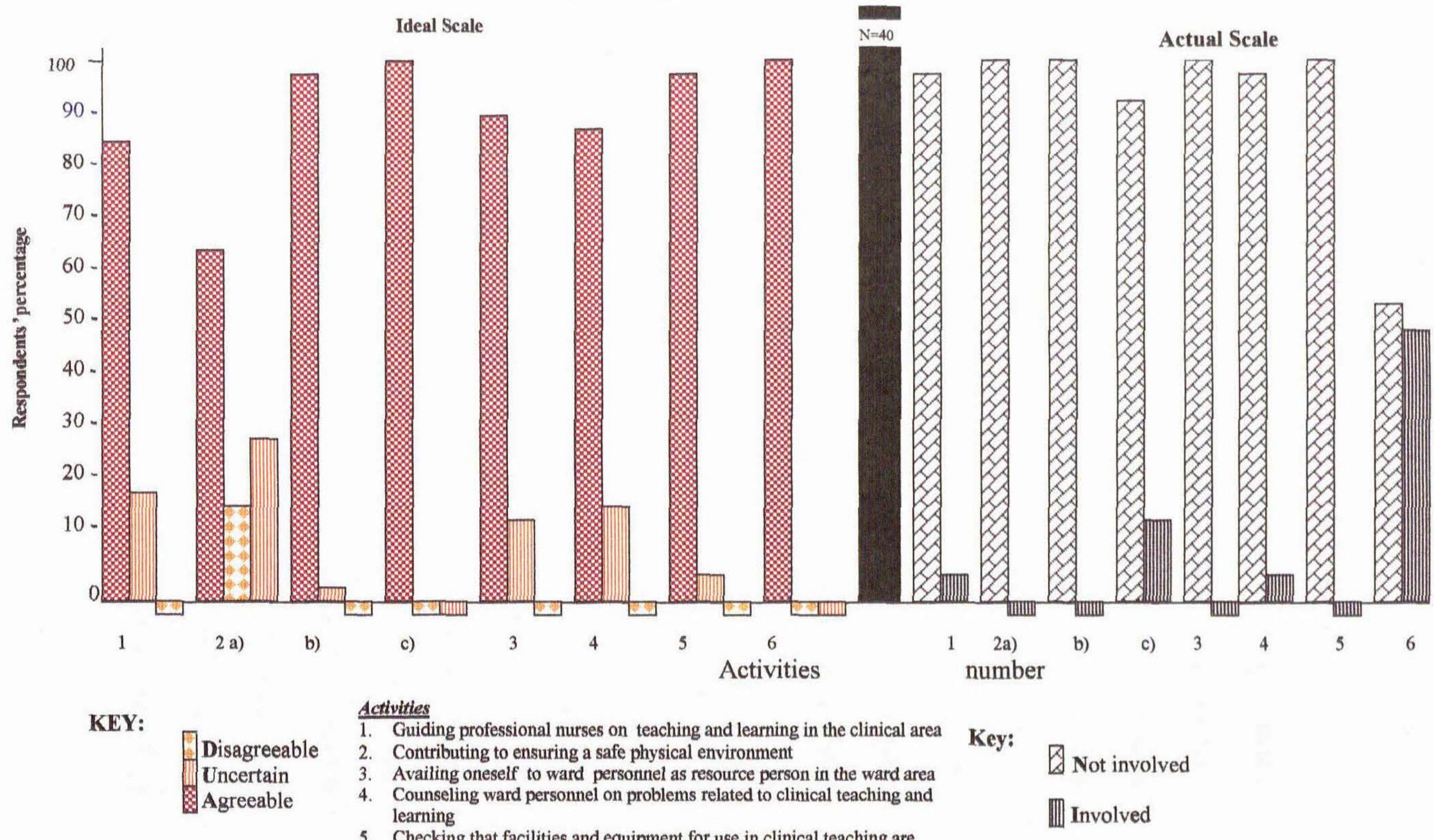
N = 40

ROLE	IDEAL SCALE					ACTUAL SCALE				
	1	2	3	4	5	1	2	3	4	5
1. Guiding professional nurses on teaching and learning in the clinical area	0	0	6 15%	2 5%	32 80%	1 2.5%	38 95%	01 2.5%	0	0
2. Contributing to ensuring a safe physical environment, e.g.										
• Prevention of accidents	0	5 12.5%	10 25%	15 37.5%	10 25%	2 5%	38 95%	0	0	0
• Promoting good student/ patient relationship	0	O	1 2.5%	8 20%	31 77.5%	2 5%	38 95%	0	0	0
• Promoting good student/ nurse relationship	0	0	0	7 17.5%	33 82.5%	O	36 90%	4 10%	0	0
3. Availing oneself to ward personnel as resource person in the ward area	0	0	4 10%	2 5%	34 85%	3 7.5%	37 92.5%	0	0	0
4. Counseling ward personnel on problems related to clinical teaching and learning	0	0	5 12.5%	10 25%	25 62.5%	4 10%	35 87.5%	1 2.5%	0	0
5. Checking that facilities and equipment for use in clinical teaching are adequate	0	0	1 2.5%	2 5%	37 92.5%	3 7.5%	37 92.5%	0	0	0
6. Encourage unit professional nurse to participate in the clinical instruction to supplement tutor's role	0	0	0	3 7.5%	37 92.5%	0	21 52.5%	9 22.5%	10 25%	0

KEY: IDEAL – 1 = Strongly disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly agree

ACTUAL - 1. = Not at all
2. = Minimal
3. = Reasonable
4. = Considerable
5. = A great deal

FIGURE 5.2 PERCENTAGE OF RESPONSES TO NURSE –EDUCATOR AS FACILITATOR OF LEARNING IN THE CLINICAL AREA (Horizontally collapsed).



Activities

1. Guiding professional nurses on teaching and learning in the clinical area
2. Contributing to ensuring a safe physical environment
3. Availing oneself to ward personnel as resource person in the ward area
4. Counseling ward personnel on problems related to clinical teaching and learning
5. Checking that facilities and equipment for use in clinical teaching are adequate
6. Encourage unit professional nurses to participate in clinical instruction to supplement tutor's role

Responses to activity 2.5.1.1:- guiding ward professional nurses on teaching and learning in the wards

Table 5.15 and figure 5.2 on the ideal scale indicate that thirty four (85%) respondents agreed that nurse educators should guide professional nurses on teaching and learning in the clinical area. Six respondents (15%) were uncertain. None disagreed with the statement. The percentage of respondents who were uncertain (even though small) is disturbing because ward professional nurses should be joint participants in the clinical teaching of students. Their role, together with the role of the nurse-educator are complementary. They are the most involved and most valuable resources for students and some of them may serve as preceptors. Therefore ward professional nurses need to be guided on how to ensure effective clinical teaching and learning in the clinical area through inservice or continuing education workshops conducted by college (Infante 1985: 134).

Table 5.15 on the actual scale depicts a very pathetic situation where only one respondent (2.5%) claimed to be involved in guiding professional nurses in the units re-clinical teaching. Thirty nine respondents (97.5%) said they did not. These findings compare poorly with the findings in the ideal scale.

In a study conducted by Cele (1990: 46) on clinical teaching of student nurses in nurse training schools in KwaZulu, 32.5% of respondents (unit professional nurses) cited lack of confidence for teaching and poor communication between college and unit personnel as reasons for poor participation in clinical teaching. Therefore ward professional nurses do need guidance and support from nurse educators.

Responses to activity 2.5.1.2:- contribution to ensure a safe physical environment

This item was subdivided into three items, namely, prevention of accidents, promotion of good student/ patient relationship and promotion of good student/ nurse relationship. Responses on the ideal scale show that twenty five respondents (62.5%) agreed that nurse educators should participate in the prevention of accidents in the wards. Ten respondents (25%) were uncertain and five (12.5%) disagreed with the statement. Responses in the actual scale were in direct contrast to the findings in the ideal scale. No respondent (0%) participated in the prevention of accidents and promotion of good student-patient relationship. Only four respondents (10%) indicated participation in the promotion of good student - nurse relationship. Thirty six respondents

(90%) indicated non participation. These findings contravene views of various nurse authors and researchers on the importance of creating an environment conducive to effective clinical teaching and learning. For instance (Mellish & Wannenburgh) as quoted by Mhlongo (1994: 56) assert that it should be emphasised to student nurses that not only the patients physical environment should be safe but also his good home and his property. They further assert that aspects of the environment which should be taught include avoidance of bad attitudes of personnel to patients and poor interpersonal relationship between patients and nursing staff and between nursing staff and student nurses. de Tornyay & Thompson (1987: 166) are of the opinion that the clinical learning climate established by the teacher has a major impact in assisting students to make the necessary applications and developing the desired competencies. Therefore creating an environment conducive to effective clinical teaching and learning is part of clinical teaching dimension and therefore the responsibility of a nurse educator.

Responses to activity 2.5.1.3:- availability of nurse educators to ward personnel as resource persons in the clinical area

As shown in table 5.15 and figure 5.2 data relating to the ideal role of the

nurse educator regarding his/ her availability to ward personnel as a resource person indicate that thirty six respondents (90%) agreed with the statement. Four respondents (10%) were uncertain. None disagreed completely with the statement. A comparison of the ideal with the actual scal shows somewhat very different reactions. In the actual scale no respondent (0%) claimed participation in availing himself/ herself to ward personnel as a resource person. These findings are extremely disturbing because nurse educators cannot hope to secure the support of ward personnel in clinical teaching to complement their role if they do not provide them with the necessary guidance and support.

This finding confirms a statement by Hinchliff (1986: 59) who states that few of the trained staff have had any guidance in how to teach and that this may produce a feeling of inadequacy. Therefore although nurse educators are probably overloaded with college-based duties, if time avails itself, they should visit the clinical area to discuss curricular goals and materials, programme objectives, ward objectives, teaching content and methods of presentation with ward professional nurses. This will forster a good spirit of understanding between college and service and make the task of ward

teaching easier (Infante 1985: 135). This statement is supported by Mhlongo (1994: 81) who states that when unit professional nurses, tutors and clinical instructors work together, they gain deeper insight into each other's role.

Responses to activity 2.5.1.4 counselling unit personnel on problems related to clinical teaching and learning.

Counselling is providing help, support and an understanding listening to someone who is concerned or perplexed. It is a helping relationship that assists the client to become self-directed and it requires tolerance and sensitivity (Quinn 1995: 206; Carpenito & Duespohl 1985: 232).

In the ideal scale thirty five respondents (87.5%) responded positively and the remaining five (12.5%) were not certain. Findings in the actual scale compares unfavourably with responses in the ideal scale and it is disheartening to note that only one respondent (2.5%) participated in counselling of unit personnel while thirty nine respondents (97.5%) did not participate in this activity.

This is in direct contrast to the findings by Cele (1990) and Clifford (1995) as

quoted by Mashaba & Brink (1994: 51) where nurse teachers perceived finding problems, talking to staff and helping them gain self-esteem as activities that they need to undertake.

Responses to activity 2.5.1.5:- checking adequacy of facilities and equipment for use in teaching nursing skills

Table 5.15 and figure 5.2 on the ideal scale show that a substantial number of respondents, (95.5%) were agreeable with the fact that it is incumbent upon nurse educators to check that facilities and equipment for use in clinical teaching are adequate. This is supported by Mchunu (1997: 69) who states that adequate resources such as equipment is essential for a supportive clinical learning milieu and that lack of resources undermines the learning process. However, responses on the actual scale depict a direct opposite to responses on the ideal scale because no nurse educator indicated she had ever taken an initiative of checking the adequacy of facilities and equipment in the clinical area.

Responses to the forthcoming discussion on implementation of clinical teaching will shed some light as to how nurse educators, for instance,

demonstrate nursing skills without having checked the availability of equipment.

Responses to activity 2.5.1.6:- encouraging ward professional nurses to participate in clinical instruction to supplement tutors role

According to Mellish & Brink (1990: 218) a great deal of clinical instruction, both formal and informal, rests in the hands of the ward professional nurse because of the expertise she has developed over years of thoughtful and observant practise. Therefore she must be given acknowledgement, support and even assistance to be able to effectively supplement the nurse educators role in the clinical setting.

All forty respondents (100%) subscribed to this idea as depicted in table 5.15 and figure 5.2 on the ideal scale. It was however disappointing to note that only nineteen respondents (47.5%) (as reflected in the actual scale) were actually involved in encouraging ward professional nurses to participate in clinical instruction. The remaining twenty one respondents (52.5%) did not involve themselves in this activity. This finding almost tally with what emerged in a study conducted by Cele (1990) where ward professional nurses

quoted poor communication between themselves and college personnel as one of the reasons why they are unable to meet their clinical instruction role.

5.6.5.2 Ideal and actual extent of participation in provision of motivation and support to students in the clinical area

According to Mashaba & Brink (1994: 46) the nurse educator should be available at the bedside to support the learner who is usually nervous and anxious. This view is shared by other authors, for instance, Hinchliff (1986: 53) supports the afore-mentioned writers by asserting that the student nurse, more especially the junior nurse may become muddled up and feel insecure in the clinical area and therefore needs extra support and supervision when necessary. This support encourages independence and self reliance among students rather than dependence and reliance on the teacher for sanctions, information needed for practice and solutions to problems. De Young (1990: 15) states that motivation is essential in bringing about and maintenance of interest in student learning and in helping them rise above mediocrity.

TABLE 5.16 PROVISION OF MOTIVATION AND SUPPORT TO STUDENTS IN THE CLINICAL AREA

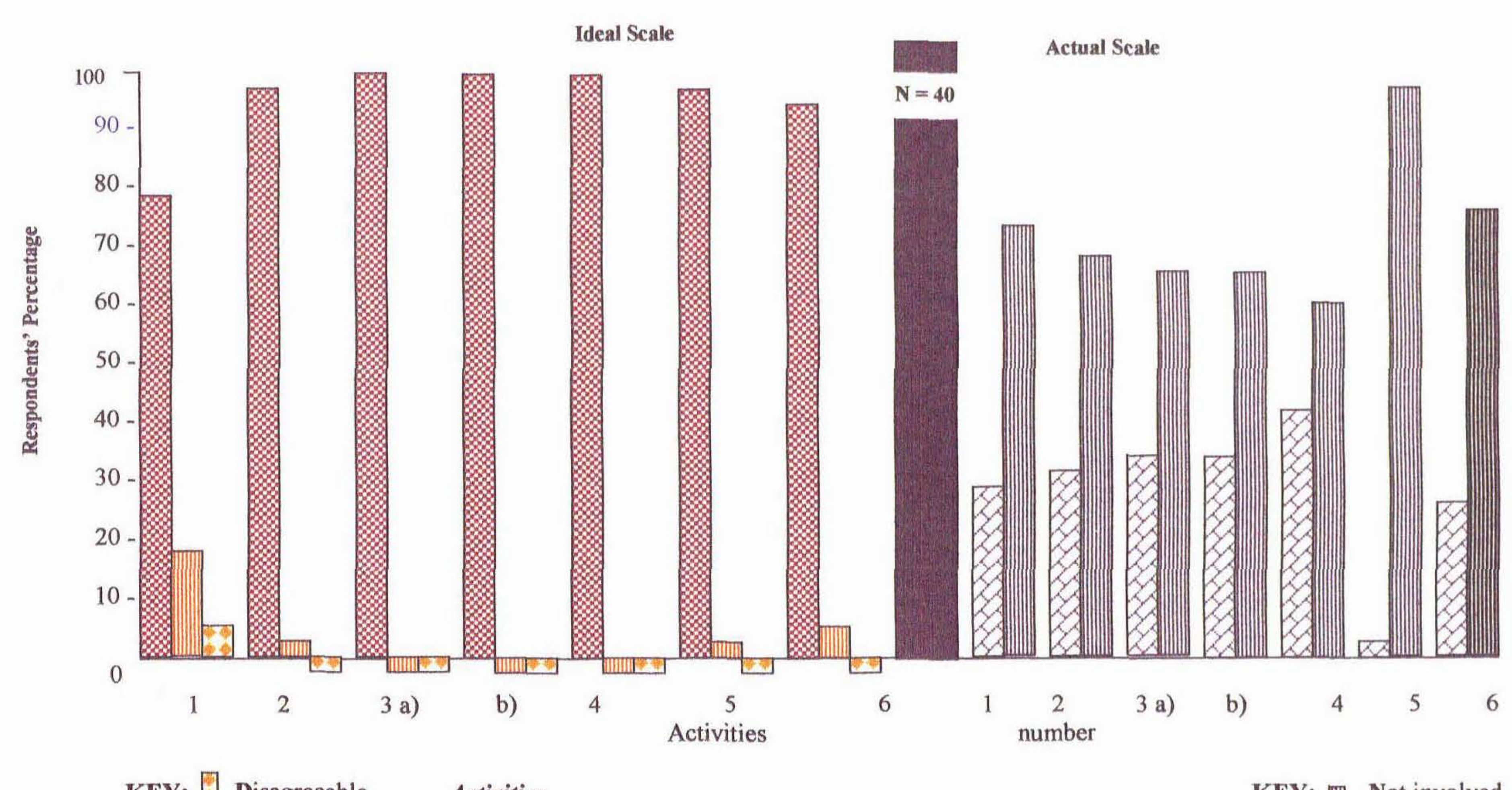
N = 40

ROLE	IDEAL SCALE					ACTUAL SCALE				
	1	2	3	4	5	1	2	3	4	5
1. Providing students with opportunities for client contact	0	2 5%	7 17.5%	31 77.5%	0	21 52.5%	8 20%	11 27.5%	0	0
2. Assisting students to apply knowledge to varied clinical situations	0	0	1 2.5%	5 12.5%	34 85%	0	27 67.5%	3 7.5%	10 25%	0
3. Providing guidance to students about, e.g. • Implementation of policies	0	0	0	10 25%	30 75%	0	26 65%	4 10%	10 25%	0
• Completion of workbooks	0	0	0	10 25%	30 75%	0	26 65%	4 10%	10 25%	0
4. Providing opportunities for the students to develop professional decision making skills and judgement, e.g. when to call a doctor	0	0	0	6 15%	34 85%	0	24 60%	6 15%	10 25%	0
5. Rewarding students for creativity, e.g. making an effective suggestion about a novel approach to a problematic situation	0	0	1 2.5%	3 7.5%	36 90%	0	39 97.5%	1 2. 5%	0	0
6. Allowing for freedom of expression and taking of initiative in the acquisition of abilities	0	0	2 5%	4 10%	34 85%	0	30 75%	10 25%	0	0

KEY: IDEAL – 1 = Strongly disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly agree

ACTUAL - 1. = Not at all
2. = Minimal
3. = Reasonable
4. = Considerable
5. = A great deal

FIGURE 5.3 PERCENTAGE OF RESPONSES TO PROVISION OF MOTIVATION AND SUPPORT TO STUDENTS IN THE CLINICAL AREA (Horizontally collapsed).



KEY: Disagreeable
Uncertain
Agreeable

Activities

1. Providing students with opportunities for client contact
2. Assisting students to apply knowledge to varied clinical situations
3. Providing guidance to students about implementation of policies, etc.
4. Providing opportunities for the students to develop professional decision making skills and judgement, e.g. when to call a doctor
5. Rewarding students for creativity, e.g. making an effective suggestion about a novel approach to a problematic situation
6. Allowing for freedom of expression and taking of initiative in the acquisition of abilities

KEY: Not involved
Involved

Responses to activity 2.5.2.1:- providing students with opportunities for client contact

Table 5.16 and figure 5.3 show that thirty one respondents (77.5%) on the ideal scale agreed that nurse educators should provide students with adequate opportunity for client contact, two respondents (5%) disagreed while seven respondents (17.5%) were uncertain. These findings compare unfavourably with those in the actual scale where only eleven respondents (27.5%) stated to have been actively involved with this activity whilst the remaining twenty nine respondents (72.5%) stated that they were not participating in this activity. It appears that a large number of respondents were not aware of their responsibility of providing students with adequate opportunity for client contact as indicated by literature when they responded to this item. For instance Infante (1985: 28) asserts that client contact is the heart of the student's activities in the clinical laboratory in nursing education. Further, she states that clinical laboratory activities provide an opportunity for learning in the kinds of situations in which learners will continue to perform as practitioners. In other words, client contact in the real situation adequately prepares the learner for his/ her future roles.

Responses to activity 2.5.2.2:- assisting students to apply knowledge to varied clinical situations

Almost all respondents, that is, thirty nine (97.5%) as depicted in table 5.16 and figure 5.3 on the ideal scale unanimously agreed that the nurse educator is responsible for assisting students to apply knowledge to varied clinical situations. Only one respondent (2.5%) was uncertain.

Literature on nursing education do point out the importance of assisting student nurses to integrate theory into practice. For instance Guinee (1966: 62), states that learning clinical skills in the laboratory setting should provide experiences which will help the student to relate theory into practice. Infante (1985: 58) echoes the same sentiment when she asserts that every opportunity should be provided to students while in the clinical laboratory to apply theory to practice. According to Mellish & Brink (1990: 217) clinical teaching is the means by which student nurses learn to apply theory of nursing so that an integration of theoretical knowledge and practical skills in the clinical situation become the art and science of nursing.

Unfortunately it is apparent from table 5.16 on the actual scale that the

majority of respondents have failed to implement what they perceive to be their ideal function because only thirteen respondents (32.5%) agreed that they were involved in assisting students to integrate theory into practice whilst twenty seven respondents (67.5%) said they did not. This is a cause for concern because theory teaching should not be separated from clinical teaching - one cannot produce a competent theoretical nurse at one time and a practical nurse at another time (Mashaba & Brink 1994: 44).

Responses to activity 2.5.2.3:- providing guidance to students about e.g. implementation of policies and completion of workbooks

It has been mentioned in the foregoing discussion that providing guidance to students is imperative to lead them to professional maturity and responsibility. De Young (1990: 7) states that although learners do not need to be "babied" they do need a great deal of guidance during clinical learning.

As shown in table 5.16 and figure 5.3 on the ideal scale, all respondents (100%) agreed that nurse educators should provide guidance to students about implementation of policies and completion of workbooks. However, findings on the actual scale do not compare with the response in the ideal scale

because out of forty respondents, only 14 respondents (35%) participated in the execution of this activity. It is disappointing to note that nurse educators do value guidance of students and yet fail to fulfill it.

Nurse educators should realize that workbooks (which are carefully designed teaching tools which have to be completed by students and submitted for scrutiny and comment) are essential because they complement their role in the clinical area during their absence (Mellish & Brink 1990: 140, Hinchliff 1986: 78).

Responses to activity 2.5.2.4:- providing opportunities for the students to develop professional decision making skills and judgement

Knowing the process of decision making and accepting full responsibility for the consequences of one's action is basic to professionalism. Therefore the student preparing to be a professional practitioner should be provided with the opportunity to learn to make judgements under guidance in selected situations. The clinical setting should at all times be utilized to provide the conditions that facilitate these kinds of experiences for students (Infante 1985: 53).

As shown in table 5.16 and figure 5.3 responses to this activity are quite pleasing because all respondents (100%) shared the view that opportunities must be availed to students during allocation in the clinical area to develop professional decision making skills. A negative and a disappointing response was gleaned from the actual scale where only sixteen respondents (40%) indicated involvement in this regard while twenty four respondents (60%) indicated that they were not involved.

The researcher assumes that the latter group of respondents do not appreciate that the clinical area is the place where the student brings to bear knowledge and skills in the solution of problems of the variety likely to be encountered in the profession. Poor execution of this activity can have adverse consequences because the student cannot suddenly develop decision making skills on completion of the course if this has not been instilled or inculcated during training.

Responses to activity 2.5.2.5:- rewarding students for creativity e.g. making an effective suggestion about a new/ novel approach to a *problematic situation.*

According to Infante (1985: 55) activities in the clinical laboratory or setting should be planned to elicit creative abilities of the students. This is done by allowing the students to try, to stumble and yes to fall while discovering their own methods of proceeding instead of being expected to mimic the actions of others. Value judgement are made as to right or wrong, effective and ineffective by the student under the guidance of the teacher before being applied to clients/ patients. The hands and minds of the student must feel free to engage in creative activity by going beyond what has been learned and rewarding him/ her for a good approach either through praise, awarding of medals etc.

Responses to this activity in the ideal scale yielded the highest score. Out of forty nurse educators who responded to this item, thirty nine (97.5%) indicated that they perceived this activity as their function and only one (2.5%) was uncertain. Responses in the actual scale compares poorly with the findings in the ideal scale because thirty nine respondents (97.5%) indicated

involvement to rewarding students for being creative in the clinical area.

Responses to activity 2.5.2.6:- allowing for freedom of expression and taking of initiative in the acquisition of abilities

As shown in table 5.16 and figure 5.3 on the ideal scale, this activity yielded the highest scores. Out of forty respondents, thirty eight (95%) agreed that allowing freedom of expression during clinical teaching should be done. Only two respondents (5%) were uncertain. A disappointing response emerged on the actual scale where only ten respondents (25%) said that they allowed for an atmosphere where students could air their views and take initiative in the acquisition of abilities. The responses in the ideal scale could suggest that nurse educators are cognizant of the importance of a climate conducive to clinical teaching and learning as stated in literature. For instance Carpenito and Deuspohl (1985: 75) propound that the teacher during clinical instruction should provide a climate that is flexible, permissive and free. Students should feel safe to disagree with the teacher without jeopardizing their positions in the nursing programme. Both the students and teachers must use every possible measure to change binding attitudes rules and policies in order to promote freedom of expression during clinical learning.

To support this, Mellish (1982:9) states that whatever the student learns, she/ he is the only one who can do the learning and every student learns at her/ his own rate. For these reasons it is important that the students be aware of their needs and problems and consult unit professional nurses at the appropriate time because their learning needs are not the same. It is the responsibility of tutors to motivate students to be responsible, self-directed and to learn to take initiative when a person has a problem/ need.

5.6.5.3 Ideal and actual extent of participation of nurse educators in assessment phase for clinical teaching

Assessment for clinical teaching is an integral component of the teaching learning process. It is aimed at diagnosing the needs of the learners, their relevant characteristics and whether they possess the necessary prerequisites for accomplishing the objectives of the educational programme. Six activities were listed to elicit information on assessment for clinical teaching (see table 5.17 and figure 5.4).

TABLE5.17 ASSESSMENT FOR CLINICAL TEACHING

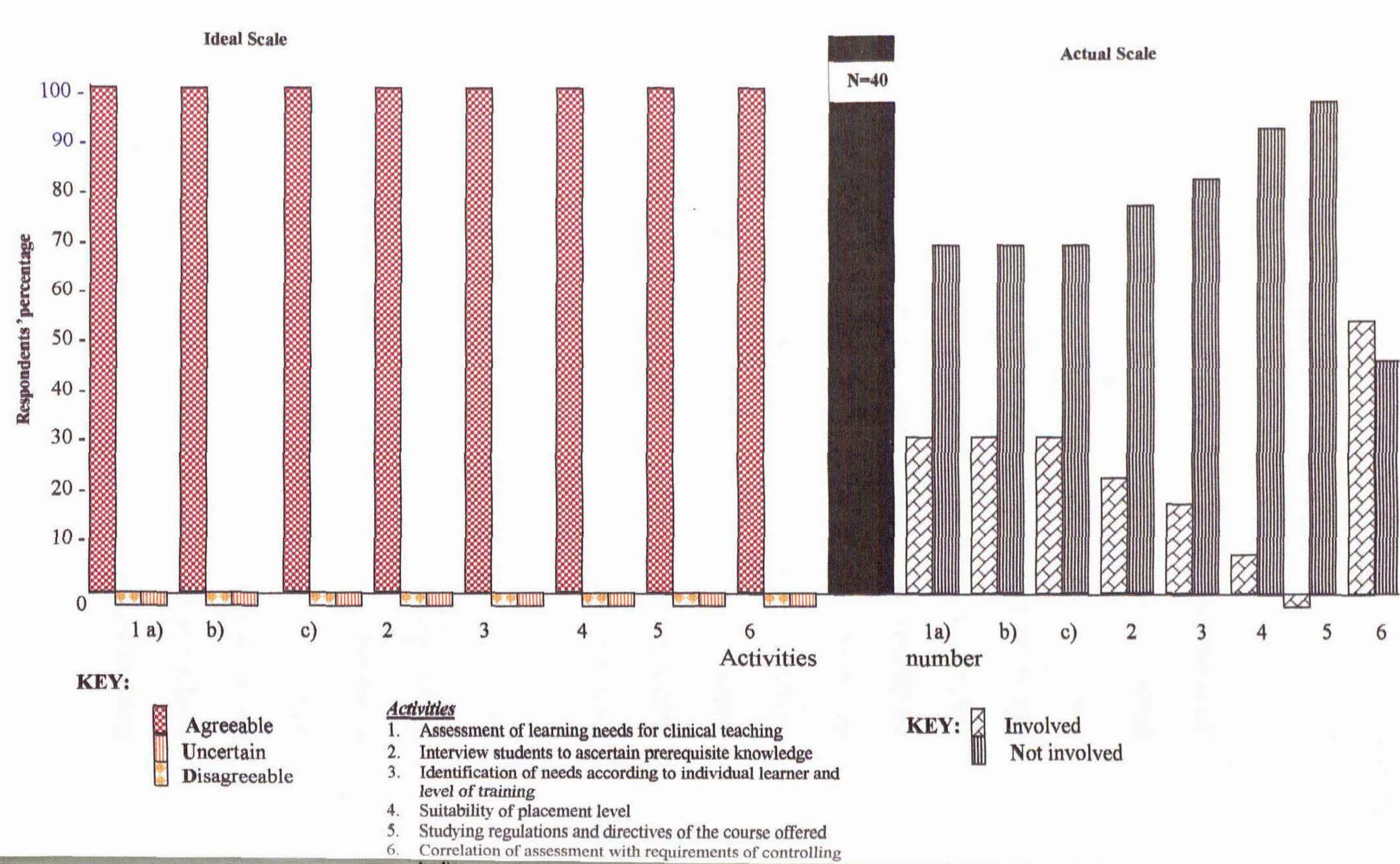
N = 40

ROLE	IDEAL SCALE					ACTUAL SCALE				
	1	2	3	4	5	1	2	3	4	5
1. Assessment of learning needs for clinical teaching:-										
• Psychomotor	0	0	0	11 27.5%	29 72.5%	0	28 70%	12 30%	0	0
• Affective	0	0	0	10 25%	30 75%	0	28 70%	10 25%	2 5%	0
• Cognitive	0	0	0	9 22.5%	31 77.5%	0	28 70%	10 25%	2 5%	0
2. Interview students to ascertain prerequisite knowledge	0	0	0	8 20%	32 80%	0	31 77.5%	9 22.5%	0	0
3. Identification of needs according to individual learner and level of training	0	0	0	7 17.5%	33 82.5%	0	33 82.5%	7 17.5%	0	0
4. Suitability of placement to level	0	0	0	6 15%	34 85%	0	37 92..5%	3 7..5%	0	0
5. Studying regulations and directives of the course offered	0	0	0	1 2.5%	39 97.5%	0	0	32 80%	8 20%	0
6. Correlation of assessment with requirements of controlling bodies	0	0	0	0	40 100%	0	18 45%	22 55%	0	0

KEY: IDEAL – 1 = Strongly disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly agree

ACTUAL - 1. = Not at all
2. = Minimal
3. = Reasonable
4. = Considerable
5. = A great deal

FIGURE 5.4 PERCENTAGE OF RESPONSES TO ASSESSMENT FOR CLINICAL TEACHING (Horizontally collapsed).



Activities

1. Assessment of learning needs for clinical teaching
2. Interview students to ascertain prerequisite knowledge
3. Identification of needs according to individual learner and *level of training*
4. Suitability of placement level
5. Studying regulations and directives of the course offered
6. Correlation of assessment with requirements of controlling bodies.

Responses to activity 2.5.3.1:- assessment of learning needs for clinical teaching i.e. psychomotor, affective and cognitive domains

For the purpose of clarity nurse educators were requested to respond differently for the three domains. The first domain was the psychomotor which deals with acquisition of motor skill. The second was the affective domain which deals with attitudes, feelings and values and the third was the cognitive domain dealing with acquistion of knowledge and understanding.

Table 5.17 and figure 5.4 depicts that responses on the ideal scale was positive because all forty nurse educators (100%) agreed that assessment of students in all three domains should be done before clinical teaching is effected. Such response was pleasing because it shows that nurse educators do realize the need to establish the learners' entry behaviours i.e. his/ her weaknesses and potentials before beginning instruction. This finding is confirmed by Huckabay (1980: 18) who asserts that assessment of entry behaviours determines where instruction must begin. Reilly and Oermann (1985: 99) share the same view and state that assessment is an important phase in the instructional process for if students lack entry behaviours for a given learning situation even high quality instruction can never be effective.

Responses on the actual scale do not compare favourably with findings on the ideal scale. While 100% of respondents perceived assessment in all domains as important, only twelve (30%) said they participated in assessment of psychomotor, affective and cognitive domains and twenty eight (70%) said they did not.

The question is how does the group of nurse educators who responded negatively begin their clinical teaching if they do not ascertain previous knowledge of student nurses.

Responses to activity 2.5.3.2:- interviewing students to ascertain prerequisite knowledge

One of the methods used to establish the pre-requisite knowledge of the student is by interviewing him/ her. Therefore the nurse educator must make time available to question the student in order to establish his/ her prior knowledge, weaknesses and potentials.

As depicted in table 5.17 and figure 5.4, all forty respondents (100%) agreed that students should be interviewed to ascertain prerequisite knowledge. This

was very pleasing. However, a disappointing picture emerged on the actual scale where only nine respondents (22.5%) said they participated in this activity and the remaining thirty one (77.5%) respondents said they did not.

Reilly & Oermann as quoted by Mhlongo (1994:79) state that interviewing the students helps in determining the affective characteristics of the learner which are interests, attitudes and self views which vary among students. Therefore interviewing the student helps the nurse educator to plan for individualised teaching.

Responses to activity 2.5.3.3:- identification of needs according to individual learner and level of training

According to Reilly & Oermann (1985: 100) identification of needs according to individual learner and level of training is essential because it reveals differences in rates of learning, cognitive styles, and cultural patterns among students relevant to planning the instruction. As shown in figure 5.4 and table 5.17, the ideal scale yielded positive responses because all respondents (100%) agreed that identification of needs of individual learner should be done during clinical teaching. But the actual scale yielded a very disappointing

picture where only seven respondents (17.5%) stated participation in this activity while the remaining thirty three respondents (92.5%) indicated non-participation. Such results undermine the value of the instructional process whose main goal is facilitation of attainment of objectives by the student.

Responses to activity 2.5.3.4:- suitability of placement in relation to level of training

Student nurses are assigned to specific nursing units to enable them to relate the sciences basic to nursing to a particular clinical situation. The nurse educator as the person who has a better knowledge and understanding of the curriculum should be actively involved in the placements of students in the clinical area to ensure that clinical learning objectives are realized. This is done in conjunction with the service personnel. Hinchliff (1986) as quoted by Mchunu (1997: 69) is of the opinion that even dates for the students' practical work must be set by college before the programme commences.

Nurse educators seem to be aware of this responsibility because table 5.14 on the ideal scale shows that all forty respondents (100%) acknowledged their responsibility in this regard. But unfortunately like in above responses, a

disheartening picture emerged in the actual scale where only three respondents (7.5%) stated to be actively involved in suitable placement of students according to level of training and the remaining thirty seven respondents (92.5%) admitted they were not involved.

Responses to activity 2.5.3.5:- studying regulations and directives of the course offered

As shown in table 5.17 and figure 5.4 on the ideal scale all forty respondents (100%) agreed that it was their ideal role to study regulations and directives of the course offered.

For the four year comprehensive diploma course which is the focus of this study, the directives are outlined in the guidelines for the course leading to registration as a nurse (general, psychiatric and community) and midwife, (R425 of 22 February 1985) as amended. In this directive the objectives of the South African Nursing Council regarding the education and training of student nurses are outlined, minimum educational requirements stipulated as well as guidelines for teaching practice. All this information provides nurse educators with a basis upon which clinical teaching is planned. The guidelines

should be studied in conjunction with the relevant regulation and should always be considered when planning clinical teaching.

An encouraging response was also obtained in the actual scale where all forty (100%) respondents conceded to be involved in studying these regulations and directives of the course offered.

Responses to activity 2.5.3.6:- correlation of one's assessment with the requirements of the controlling bodies

As illustrated in Table 5.17 and figure 5.4 on the ideal scale all forty respondents (100%) agreed that data collected during assessment should be correlated with requirements of the controlling bodies. The actual scale reveals that twenty two respondents (55%) were performing this activity. This is important because as stated above in activity 2.5.3.5, before assessing students for clinical teaching, the nurse-educator should study the philosophy, policies and regulations of the S.A.N.C. and then correlate his/ her assessment and planning with these requirements to ensure maintenance of good standards of nurses education and training.

On evaluating the overall responses on the assessment of students for clinical teaching (item 2.5.3) the researcher can deduce that nurse educators do not adequately practise assessment activities despite the fact that they perceived almost all activities to be their ideal responsibilities. Apparently little or no improvement has been made in this regard because Cele (1990: 27) stated in her study that the value of the model for instructional process has been neglected.

5.6.5.4 Ideal and actual extent of participation in planning for clinical teaching

Professional teaching is characterized by an acceptance of responsibility for facilitating other people's learning through planned and purposeful educational intervention. When planning the type of course, the year or level, the prior experience of students and the course aims and learning outcomes should be considered. Therefore the nurse educator must be actively involved in planning for clinical teaching if it has to be effective. Planning in instruction is represented by setting objectives which must be very explicit (Quinn 1994: 113).

TABLE 5.18 PLANNING FOR CLINICAL TEACHING

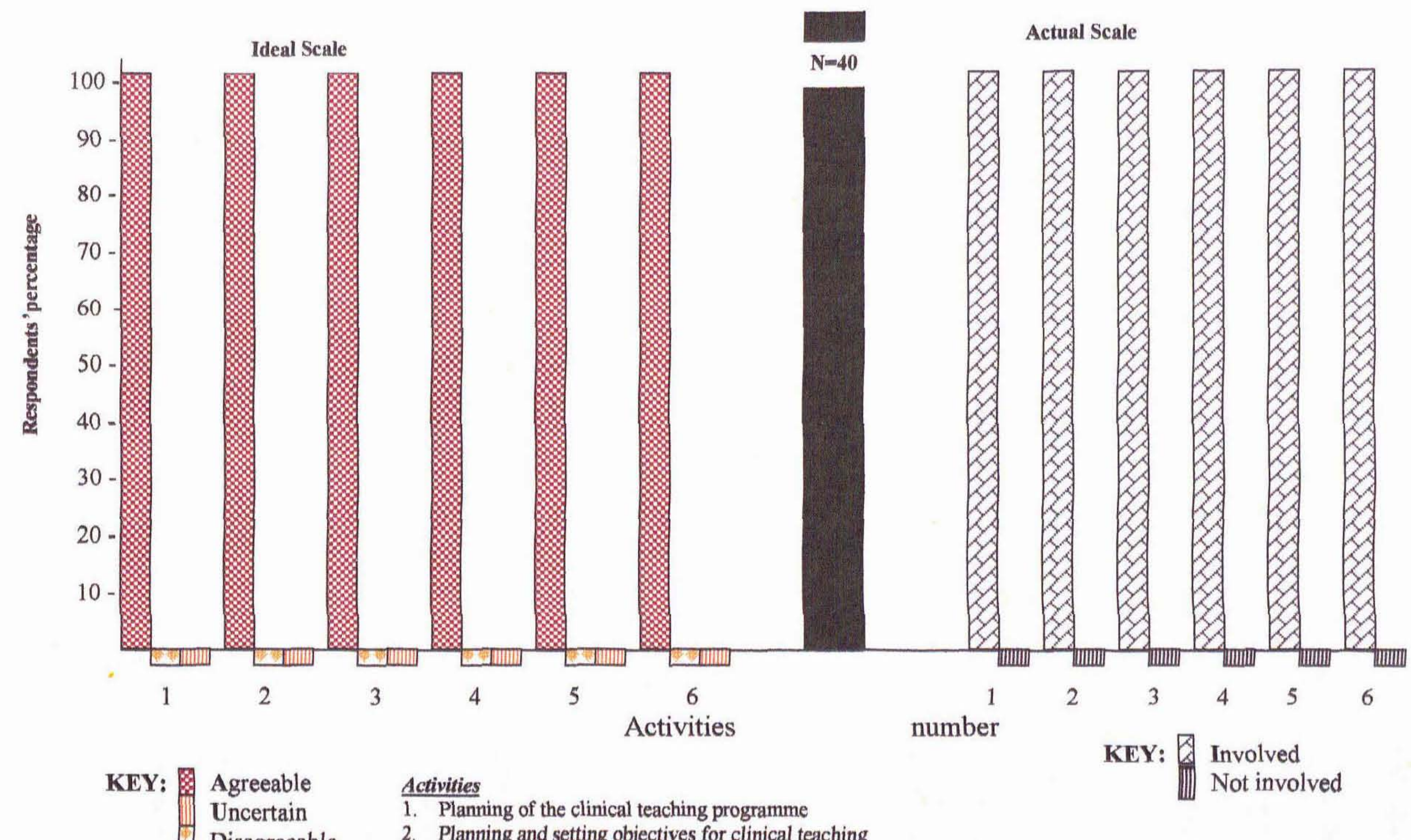
N = 40

ROLE	IDEAL SCALE					ACTUAL SCALE				
	1	2	3	4	5	1	2	3	4	5
1. Planning of the clinical teaching programme	0	0	0	0	40 100%	0	0	25 62.5%	15 37.5%	0
2. Planning and setting objectives for clinical teaching	0	0	0	0	40 100%	0	0	30 75%	10 25%	0
3. Planning/ preparing of evaluation instruments	0	0	0	0	40 100%	0	0	36 90%	4 10%	0
4. Planning for evaluation of students' clinical proficiency	0	0	0	0	40 100%	0	0	39 97.5%	1 2.5%	0
5. Planning of in-service education programmes for ward personnel pertaining to clinical teaching	0	0	0	0	40 100%	0	0	27 67.5%	13 32.5%	0
6. Ensuring that clinical teaching/ learning keep up to date with the latest developments, e.g. introduction of new approaches to teaching and caring	0	0	0	0	40 100%	0	0	34 85%	6 15%	0

KEY: IDEAL –
1 = Strongly disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly agree

ACTUAL -
1. = Not at all
2. = Minimal
3. = Reasonable
4. = Considerable
5. = A great deal

FIGURE 5.5 PERCENTAGE OF RESPONSES TO PLANNING FOR CLINICAL TEACHING (Horizontally collapsed).



Activities

1. Planning of the clinical teaching programme
2. *Planning and setting objectives for clinical teaching*
3. Planning/ preparing of evaluation instruments
4. Planning for evaluation of students' clinical proficiency
5. Planning of in-service education programmes for ward personnel pertaining to clinical teaching
6. Ensuring that clinical teaching/ learning keep up to date with the latest developments, e.g. introduction of new approaches to teaching and caring

Responses to activity 2.5.4.1:- planning for the clinical teaching programme

Table 5.18 and figure 5.5 show an encouraging responses both on the ideal and actual scale. All forty respondents (100%) agreed that planning for clinical teaching is the function of the nurse educator and again all forty respondents (100%) on the actual scale indicated involvement in this activity. Planning of the teaching programme is an important component of clinical teaching. This is supported by Quinn (1995: 123) who states that a teaching plan helps to minimize the chances of omitting some vital part of the syllabus and ensure that all necessary factors have been considered.

Responses to activity 2.5.4.2:- planning and setting objectives for clinical teaching

Instructional objectives are important both for the teacher and the learner. The teaching objectives focus on what the teacher wishes to accomplish during the period of instruction. Learning objectives focus on what the learner should be able to do, know, or feel after instruction is completed. Learning objectives can be classified into three types namely cognitive, affective and psychomotor (See item 2.5.3 activity 2.5.3.1). Setting objectives is crucial in

clinical teaching and for each laboratory or clinical session an objective should be stated clearly to the student to give him a sense of where he is going in any given instance of activity (Van Hoozer et al. 1987: 76; Infante 1985: 31).

Both the ideal and actual scales yielded very positive results where-in all forty respondents (100%) perceived setting objectives as an important component of clinical teaching and with all of them (100%) being actively involved in the process.

Responses to activity 2.5.4.3:- planning / preparing of evaluation instruments

Yet another positive response was gleaned from table 5.18 and figure 5.5 on preparation of evaluation instruments by nurse educators. On the ideal scale, all forty respondents (100%) were agreeable that they should be engaged in this activity. The response on the actual scale compares well with that on the ideal scale because all nurse educators (100%) stated that they were involved in preparing evaluation instruments. According to Van Hoozer et al. (1987: 279) the goal of learner evaluation is to find out to what degree learners have attained the knowledge, attitudes and skills emphasized in a learning

experience. Evaluation requires preparation of evaluation instruments which are written guides used to systematically record and weigh data. These evaluation instruments serve as reminders of the activities that have been accomplished and give clues as to what remains to the accomplished. Mellish & Brink (1990: 308) suggest that when drawing up the evaluation instruments, the following criteria for clinical competence should be included:-

- checking any necessary orders
- preparing the patient and equipment
- dexterity
- gentleness in carrying out the procedure
- technical skills
- patient-nurse relationship
- knowledge of theory upon which technique is based
- knowledge of the dangers/ medico-legal hazards involved in the technique and how to avoid these
- achievement of objective with minimal discomfort to the patient
- recording and reporting
- ability to deal with untoward happening during the procedure
- professionalism

Responses to activity 2.5.4.4 planning for evaluation of students clinical proficiency

Scores on the ideal scale show that the above activity was checked by all forty respondents (100%) as their ideal function. Again in the actual scale all forty respondents (100%) said they participate in the actual planning for evaluation of students clinical proficiency.

Evaluations can be conducted during learning experiences to provide feedback to learners on their progress towards meeting the objectives of the learning process - this is referred to as formulative evaluation. The second type is called summative evaluation and this measures the learner's ability to practise nursing at a safe level at the end of the course.

Responses to activity 2.5.4.5:- planning of in-service education programmes for unit personnel pertaining to clinical teaching

As illustrated in table 5.18 figure 5.5 on the ideal scale all forty respondents (100%) viewed planning of in-service education programmes for unit personnel as their ideal role. The actual scale reflected the same response where forty nurse educators (100%) indicated that they participate in this

activity. It is interesting to see a clash of ideas between this activity and activities on item 2.5.1 (activities 2.5.1.1 and 2.5.1.3) where respondents stated that they did not guide professional nurses on teaching and learning in the clinical area and that they did not avail themselves as resource persons in the units.

Nurse educators and unit professional nurses need to collaborate to ensure that effective clinical teaching programmes are conducted in the units. Their roles should be mutually supportive. To ensure this nursing college should periodically conduct in-service or continuing education workshops for unit professional nurses so as to effectively carry out their educational role in the clinical setting. Likewise nurse educators who lacked clinical skills could be assisted by unit professional nurses during these workshops or in-service education sessions. During these sessions the following could be achieved:-

- unit professional nurses would be made aware of latest developments in education and training of students
- nursing college would have influence on upgrading the level of practice in settings used by students and in turn unit professional nurses could

serve as desirable role models for the students

- college assistance in guiding professional nurses to identify research problems and design research protocols would be much appreciated
- nurse educators could be updated on new developments in clinical nursing
- demonstration of interest in nursing service and cooperation could help to improve that much needed relationship (college & service need each other)
- sharing of curricular goals, description of the philosophy of the college, programme objectives and course syllabi could be done (Infante 1985: 135, Searle, Campbell & Ehlers 1986: 265).

Responses to activity 2.5.4.5:- ensuring that clinical teaching / learning keeps up to date with latest developments

As illustrated in table 5.18 and figure 5.5 on the ideal scale all forty respondents (100%) agreed that it is their responsibility to ensure that clinical teaching and learning keep up to date with latest developments. This response compares favourably with that in the actual scale where again all forty respondents indicated involvement in this regard.

This reaction is supported by Mellish & Brink (1990: 337) who state that nurse educators belong to the groups that require inservice education to ensure that what they teach both in the classroom and clinical setting is relevant. They further assert that the nurse educator must ensure that the best quality of nursing care possible according to today's and even tomorrow's knowledge, and not according to what was thought to be correct only last year, is given.

The researcher has found it gratifying that almost all nurse educators are mindful of their role when it comes to planning for clinical instruction. However it is yet to be seen on the forth coming discussion on implementation (item 5.6.5.5) how much of this good planning is put into practice.

5.6.5.5. Ideal and actual extent of participation of nurse educators in implementation of clinical teaching

This is the critical stage of the instructional process and entails carrying out the designed plan. It entails actual instruction of students and can be formal or non formal. Benor & Leviyof (1997: 206) state that the centrality of clinical instruction in nursing education cannot be overstressed. It is a challenge to nurse educators because guiding student nurses' development in

the clinical setting requires in-depth knowledge of the practice of nursing and the ability to transmit that knowledge to students. The level of responsibility and accountability demanded of the nurse educator is not comparable with that required of faculty teaching in the classroom (Schuster et al. 1997: 154). Responses reflected in table 5.19 and figure 5.6 will shed some light as to how nurse educators involve themselves in this task.

TABLE 5.17 IMPLEMENTATION OF CLINICAL TEACHING

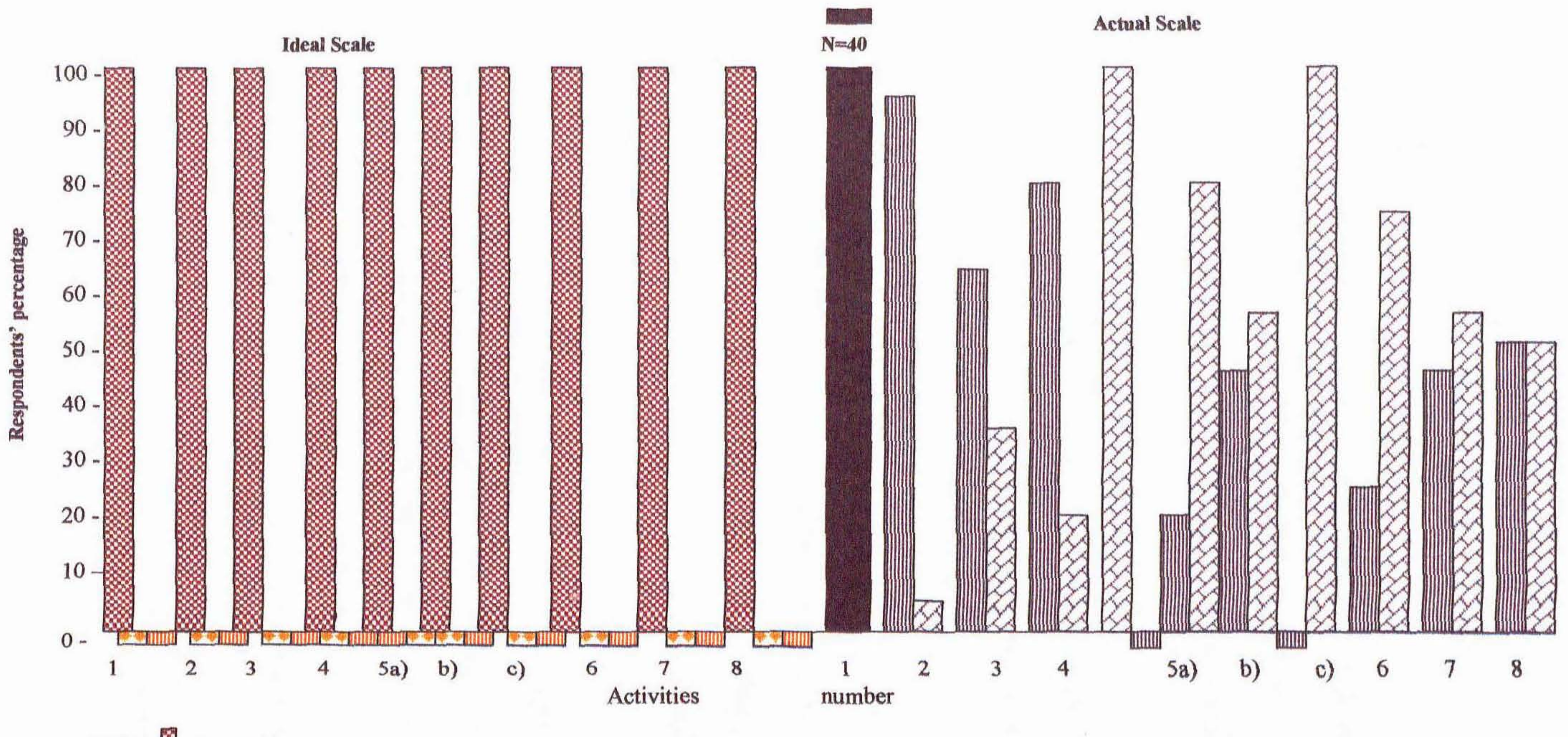
N = 40

ROLE	IDEAL SCALE					ACTUAL SCALE				
	1	2	3	4	5	1	2	3	4	5
1. Accompaniment of students in the clinical area	0	0	0	0	40 100%	2 5%	36 90%	02 5%	0	0
2. Demonstration of nursing skills to students	0	0	0	0	40 100%	0	26 65%	6 15%	8 20%	0
3. Supervising the correct and appropriate completion of clinical workbooks	0	0	0	0	40 100%	0	32 80%	6 15%	2 5%	0
4. Creation of opportunities for students to do proficiencies	0	0	0	2 5%	38 95%	0	0	31 77.5%	9 22.5%	0
5. Making best use of appropriate teaching methods, e.g.										
• Use of teachable moments	0	0	0	2 5%	38 95%	0	8 20%	32 80%	0	0
• Discussion of case studies in clinical area	0	0	0	0	40 100%	0	18 45%	22 55%	0	0
• Teaching according to set objectives	0	0	0	0	40 100%	0	0	40 100%	0	0
6. Ensuring maximum integration of theory and practice	0	0	0	0	40 100%	0	10 25%	30 75%	0	0
7. Consulting ward personnel to discuss problems/ needs related to clinical instruction	0	0	0	0	40 100%	0	18 45%	20 50%	2 5%	0
8. Implementing research findings on clinical learning and teaching	0	0	0	0	40 100%	0	20 50%	18 45%	2 5%	0

KEY: IDEAL – 1 = Strongly disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly agree

ACTUAL - 1. = Not at all
2. = Minimal
3. = Reasonable
4. = Considerable
5. = A great deal

FIGURE 5.6 PERCENTAGE OF RESPONSES TO IMPLEMENTATION OF CLINICAL TEACHING (Horizontally collapsed).



KEY: Agreeable
Uncertain
Disagreeable

Activities

1. Accompaniment of students in the clinical area
2. Demonstration of nursing skills to students
3. Supervising the correct and appropriate completion of clinical workbooks
4. Creation of opportunities for students to do proficiencies
5. Making best use of appropriate teaching methods
6. Ensuring maximum integration of theory and practice
7. Consulting ward personnel to discuss problems/ needs related to clinical instruction
8. Implementing research findings on clinical learning and teaching

KEY: Involved
Not involved

Responses to activity 2.5.5.1:- accompaniment of students in the clinical area

As depicted in table 5.19 and figure 5.6 all forty respondents (100%) agreed that they view this activity as their function. However, a disappointing response emerged on the actual scale where out of forty respondents, only two (5%) stated that they were participating in the accompaniment of students in the clinical area.

Literature abounds in statements that although clinical instruction should be a shared responsibility, (nurse educators and unit professional nurses) nurse educators should be seen taking a leading role because they are seen as persons with special attributes that would definitely benefit students and staff. Hinchliff (1986) as cited by Mchunu (1997: 78) is of the opinion that learning requires continuity from theory to practice and that this is facilitated by the presence of nurse educators in the clinical area.

Responses to activity 2.5.5.2:- demonstration of nursing skills to students

In this activity all respondents (100%) in the ideal scale agreed that the nurse educator should demonstrate nursing skills to students. In the actual scale

only fourteen respondents (35%) stated participation in this function while twenty six (65%) said they did not. Scores reflecting non-participation were high and unpleasing. Demonstrations involves a presentation of how to perform a procedure or task, how to use equipment or how to interact with clients or others. If this is not done for students how can they be expected to be skilled practitioners of nursing on completion of training? This requires further attention. This finding almost tallies with the finding by Mchunu (1997: 97) where only thirty five percent (35%) of respondents (nurse educators) indicated that they were demonstrating nursing skills for students.

Responses to activity 2.5.5.3:- supervising the correct and appropriate completion of clinical workbooks

The ideal scale yielded once again high scores in this activity. All forty respondents (100%) agreed that students should be assisted in completing their workbooks correctly. The actual scale reflected that only eight respondents (20%) managed to carry out this task, while thirty two of them (80%) stated that they were not involved. It was stated in activity 2.5.2.3 that workbooks are carefully designed teaching tools which have to be completed by students and later submitted for scrutiny and comment. It is the

responsibility of the nurse educator to guide students on appropriate completion of these clinical workbooks if they are to serve its educational value. Probably nurse educators have not yet realized the value of workbooks as mentioned by Hinchliff (1986: 78) who states that workbooks which should be given to each student at the start of allocation in the clinical setting complement the ward learning programme and provide further guidelines for learning.

Responses to activity 2.5.5.4 :- creating opportunities for students to do proficiencies

Table 5.19 and figure 5.6 on the ideal scale depicts that all forty respondents (100%) agreed with the idea that opportunities should be created for students to do proficiencies. Although a pleasing response was also reflected in the actual scale where again all forty respondents indicated participation in this activity, the question is - who had demonstrated nursing skills for students because in activity 2.5.5.2 the majority of nurse educators (65%) stated that they could not demonstrate for students. Proficiencies are always preceded by demonstrations and they entail allowing the student to try out the procedure being observed by the teacher to ascertain whether the skill has been

mastered, and to allow him/ her to develop confidence in performance.

Therefore it appears that nurse-educators only availed themselves to students when they did proficiencies but not for demonstrations.

Responses to activity 2.5.5.5:- making best use of appropriate teaching methods

This activity has three examples of activities to which nurse educators had to respond differently. The examples are:-

Use of teachable moments

A "teachable moment" is described by Mellish & Brink (1990: 156) as the moment during nursing care when something occurs to make immediate intervention desirable and which can be used to impart knowledge to students involved in the particular caring incident. It occurs without serious planning but unfortunately it is much more readily available to the trained staff in a unit than to tutors from outside.

As illustrated in table 5.19 and figure 5.6 in the ideal scale all forty respondents (100%) checked this activity as their ideal function. The findings in the actual scale almost compares with the response in the ideal scale

because thirty two respondents (80%) stated that they were involved in this activity while only eight (20%) were not involved.

Discussion of case studies in the clinical area

Case studies represents a holistic picture of the client's health problems and requires more in-depth analysis of these problems. A case study is based on the client/ patient for whom the student is responsible for care and it promotes problem-solving learning. Analysis of a case provides opportunity for the students to:-

- examine the interrelationships of multiple phenomena in the clinical situation
- enlarge own knowledge base
- acquire skill in problem solving
- examine creative approaches to the solutions of problems and present a supporting rationale for them
- organize ideas logically in written form. (Reilly & Oermann 1985: 111).

Nurse educators need to make time available to discuss with students

individual case studies.

In this activity all forty respondents (100%) on the ideal scale were agreeable that it was their responsibility to discuss case studies with students as stated in literature. An almost comparable response was reflected in the actual scale where the majority of respondents, thirty two (80%) said they participated in this function.

Teaching according to set objectives

According to Mhlongo (1994: 96) objectives for clinical teaching provide the framework for teaching in the clinical area since they specify the learning outcomes to be achieved and give direction in the selection of teaching methods and learning experiences. They are therefore seen as milestones on the road to achievement of some definite goals. Objectives should aim at bringing about a change in the behaviour of the student in all three domains, that is, cognitive, psychomotor and effective. When effecting clinical teaching in the units, the nurse educator should take into consideration the set objectives. To teach a skill without explaining its context in the total structure is an uneconomical use of time.

As depicted in table 5.19 and figure 5.6 in the ideal scale all forty respondents (100%) agreed that teaching in the clinical setting should follow set objectives. The actual scale illustrates a positive response where thirty two nurse educators (80%) stated to be doing this task while only eight respondents (20%) stated non-participation. The latter group is probably doing clinical teaching aimlessly as Searle (1986: 159) states that to teach without objectives is like taking a journey without a destination.

Responses to activity 2.5.5.6 :- ensuring maximum integration of theory and practice

As stated in chapter two of this research and also in activity 2.5.2.2 it is the responsibility of the nurse educator to ensure that the theory that the student has gained in the classroom is applied to practice to enable the student to realise the value of studying these subjects in relation to his/ her goal of competent nursing intervention. This is essential because nursing is a practice discipline. A nurse who is a theoretician is no nurse. Academic knowledge without the ability to translate it into practice is useless (Mellish & Brink 1990: 217; Mashaba & Brink 1994: 45). All forty respondents (100%) in the ideal scale perceived ensuring maximum integration of theory and practice as

their ideal function. In the actual scale thirty two respondents (80%) said they participate in this function while ten (20%) said they did not. This finding compares with the response in the ideal scale and it needs to be commended.

Responses to activity 2.5.5.7:- consulting unit personnel to discuss problems/ needs related to clinical instruction

Response in the ideal scale on this activity reveal that all forty respondents (100%) were agreeable that consulting unit personnel to discuss problems related to clinical instruction should be their responsibility. An almost positive response also emerged in the actual scale where twenty two respondents (55%) stated to be doing this activity while eighteen (45%) did not. This response does not tally with the reaction on activity 2.5.1.4, (counselling unit personnel on problems related to clinical teaching) where only one respondent (2.5%) gave a positive reaction whilst the remaining thirty nine (97.5%) stated to the contrary. One wonders if nurse educators did realize the relation between the two activities.

This aspect needs to be explored further because in a study by Cele (1990: 46) unit professional nurses cited poor communication between service and

college personnel as one of the reasons why unit professional nurses fail to meet their clinical instruction role. They were quoted as saying:-

"Tutors must make their visits more meaningful, most of the time when they do come they just wonder about and then leave without talking to any of us".

Responses to activity 2.5.5.8:- implementing research findings on clinical teaching and learning

Nursing and nursing education as a profession and practice discipline needs to develop its own body of knowledge. When planning the curriculum, nurse-educators must base practice upon theory i.e. a body of knowledge that has been researched. The research findings are also essential for clinical teaching because they determine the approach to student assessment, underline the plans, guide intervention during clinical teaching and learning and suggest questions for evaluation (Infante 1985: 166). Therefore it is incumbent upon nurse-educators that recommendations on research findings related to clinical teaching are implemented. Hinchliff (1986: 254) states that present day teachers have the additional responsibility of ensuring that they are equipped to utilise research findings to the benefit of patients and future learners.

The response to this activity shows that all forty nurse educators (100%)

agreed that implementing research findings on clinical teaching and learning was their ideal function. In the actual scale, responses show that twenty respondents (50%) said they participated in this activity and another twenty (50%) stated that they did not participate.

After summarising the planning phase of the instructional process, the researcher stated that it was yet to be seen on the implementation phase the degree to which such good planning was effected practically. Well, although there are some areas needing improvement, it was gratifying to note that nurse educators tried their level best to make sure that what they have planned was realized. What was also pleasing is that what nurse educators viewed as their function on the ideal scale was implemented satisfactorily in the actual scale. The highest positive score was 100% for teaching according to set objectives followed by 80% for use of teachable moments. The lowest score which was disappointing and worrying was recorded in the actual scale for accompaniment of students in the clinical area where only two respondents (5%) gave a positive response while the remaining thirty eight (95%) stated non-participation in this activity.

5.6.5.6 Ideal and actual extent of participation of nurse educator in clinical evaluation of clinical teaching

Clinical evaluation is done to determine whether students are becoming clinically competent in the practice of nursing. Various clinical competencies are tested at various stages of the course so that at the end of it, having passed all examinations on the way to completion, the student can be certified as clinically competent to practise nursing. This is important to protect society, which is the main concern of the South African Nursing Council. Lawrence and Lawrence as quoted by Van Hoozer et al. (1987:181) suggest that clinical evaluation is ultimately a means for promoting quality client care and as such a critical parameter that must be addressed by the nurse educator. As stated in chapter II of this research as well as in activity 2.5.4.3, clinical evaluation can be formative and or summative.

In this item nurse educators were requested to indicate their involvement in this activity. Smith (1977) as cited by Mchunu (1997: 80) asserts that nurse educators should make it known that they are responsible for evaluating students' clinical work. Table 5.20 and figure 5.7 will shed some light on what nurse educators perceive to be their ideal function in evaluating students' performance and the degree to which they involved themselves in this activity.

TABLE 5.20 NURSE EDUCATOR AS EVALUATOR OF CLINICAL LEARNING

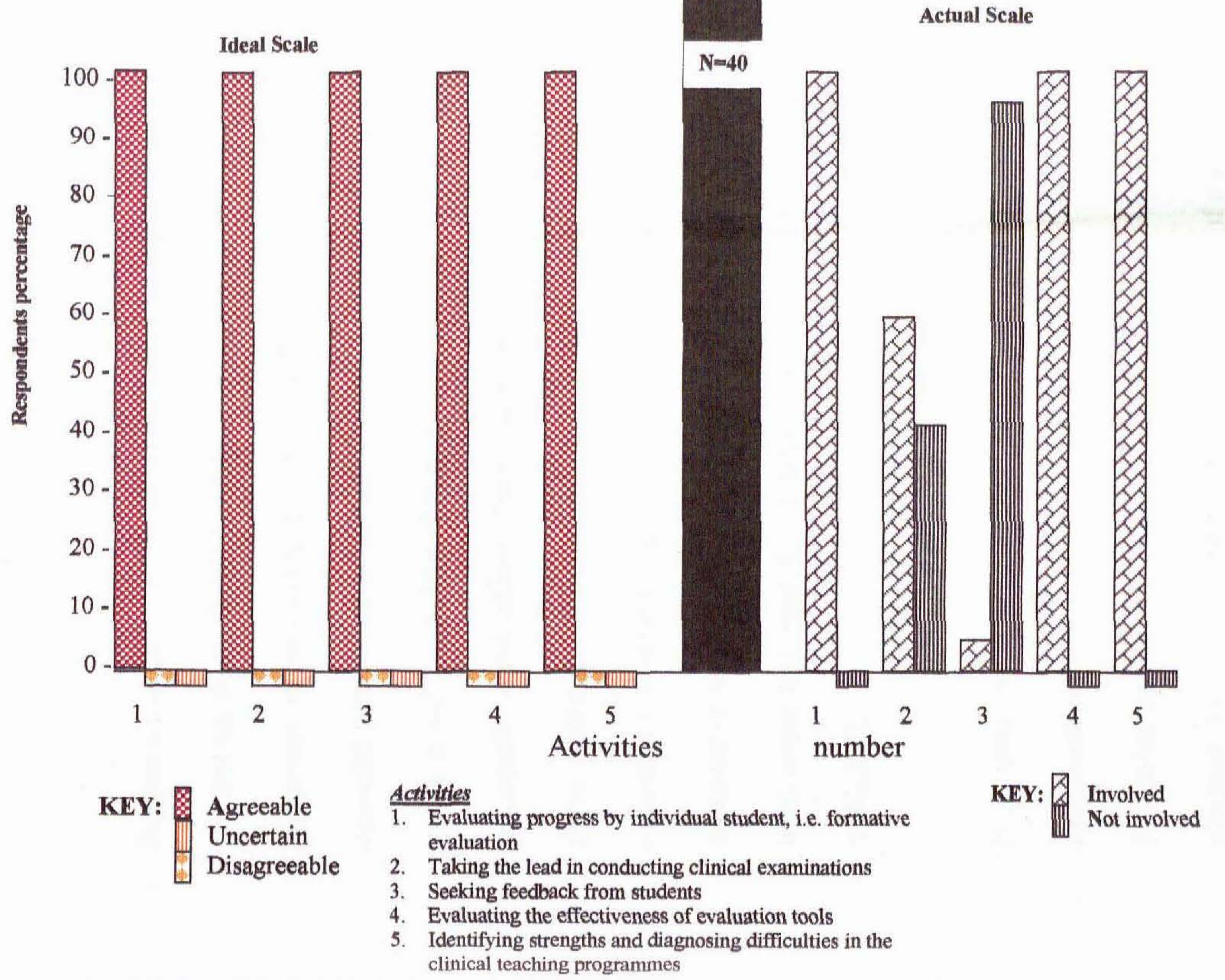
N = 40

ROLE	IDEAL SCALE					ACTUAL SCALE				
	1	2	3	4	5	1	2	3	4	5
1. Evaluating progress made by individual student, i.e. formative evaluation	0	0	0	0	40 100%	0	0	30 75%	10 25%	0
2. Taking the lead in conducting clinical examinations	0	0	0	0	40 100%	0	16 40%	24 60%	0	0
3. Seeking feedback from students	0	0	0	0	40 100%	0	38 95%	2 5%	0	0
4. Evaluating the effectiveness of evaluation tools	0	0	0	0	40 100%	0	0	32 80%	8 20%	0
5. Identifying strengths and diagnosing difficulties in the clinical teaching programmes	0	0	0	0	40 100%	0	0	25 62.5%	15 37.5%	0

KEY: IDEAL –
1 = Strongly disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly agree

ACTUAL –
1. = Not at all
2. = Minimal
3. = Reasonable
4. = Considerable
5. = A great deal

FIGURE 5.7 PERCENTAGE OF RESPONSES TO EVALUATION OF LEARNING IN THE CLINICAL AREA (Horizontally collapsed).



Activities

1. Evaluating progress by individual student, i.e. formative evaluation
2. Taking the lead in conducting clinical examinations
3. Seeking feedback from students
4. Evaluating the effectiveness of evaluation tools
5. Identifying strengths and diagnosing difficulties in the clinical teaching programmes

Responses to activity 2.5.6.1 :- evaluating progress made by individual student i.e. formative evaluation

Responses in the ideal scale shows that all forty nurse educators (100%) conceded that evaluating students formatively was their function. Responses in the actual scale show that all forty respondents (100%) were actually participating in this activity. Such response is pleasing because it shows that nurse educators do appreciate the importance of evaluation in nursing. Formative evaluation is ongoing feedback given to the learner throughout the semester or year. Its aim is to help the learner identify his strengths and weaknesses and meet the objectives of the course efficiently (De Young 1990:207).

Responses to activity 2.5.6.2 taking the lead in conducting clinical examinations

Assessing clinical competence is a difficult task which is nevertheless absolutely vital. It is usually the least favourite task of nurse educators yet it is inescapable. Although clinical evaluation is a shared responsibility with unit professional nurses (should be part of the everyday work of every unit professional nurse) the nurse educator should be seen taking a leading role

precisely because evaluation should be done according to set objectives which are congruent with the philosophy, overall programme objectives guidelines and policies from controlling bodies. The person who has best knowledge and comprehension of these is the nurse educator (Mellish & Brink 1990: 308).

Although table 5.20 and figure 5.7 on the ideal scale reflects that all forty respondents (100%) conceded that nurse educators should take a leading role in the clinical examination of students, a figure slightly lower than this, twenty four respondents (60%) in the actual scale stated to be executing this activity. The remaining sixteen respondents (40%) indicated non-participation. The question remains as to how the latter group decide whether the learner is ready, competent and proficient for promotion to the next level.

Responses to activity 2.5.6.3:- seeking feedback from students

Students should be given the opportunity to examine their performance, place a value judgement and be aware of possible problem areas. This will help increase the validity and reliability of judgements. A student who knows the objectives well, and knows the behaviours expected at a given time has a major role to play, not only in working toward goal achievement, but in

evaluating his or her outcomes. Infante (1985: 155) suggests holding a student-teacher evaluation conference to compare judgements made, explore substantiating data and arrive at a mutual decision.

As illustrated in table 5.17 figure 5.10 on the ideal scale, all forty respondents (100%) acknowledged this activity to be their function. However a very disappointing response was revealed in the actual scale where only two respondents (5%) indicated participation in this activity. The remaining thirty eight respondents (95%) indicated non-participation. Perhaps nurse educators need to be reminded that the validity of evaluation is more convincing to the student when a joint effort is made.

Responses to activity 2.5.6.4:- evaluating the effectiveness of evaluation tools

Any evaluation process requires paper and pencil guides to systematically record and weigh data. Such guides are referred to as the tools for clinical evaluation. Some tools are appropriate for formative evaluation e.g. checklists and others are typically used for summative evaluation e.g. rating scale. Nurse educators need to jointly consider and decide upon the clinical

evaluation tools to be selected and used. There are some basic criteria underlying useful tools. These are:-

- behavioural objectives determine the basis for evaluation criteria
- the specific student behaviours observable only in clinical practice are explicitly stated
- instructions for using the tool are carefully stated in writing for the user
- same tools to be used by all parties involved in the evaluation process
- sample behaviours are included for each category
- space is provided for recording supportive evidence
- provides for natural order of sequence
- space is provided for recording general statements, summaries and recommendations
- instructions for weighting are clear and space is provided to record that weighting (Infante 1985: 157).

The tools need to be evaluated periodically by nurse educators to make sure that they are effective and that they are still directly related to what is being tested.

Ideal scale shows that all forty respondents (100%) agreed that evaluating the

effectiveness of evaluation tools should be the responsibility of nurse educators. This response compares unfavourably with the response in the actual scale where only eight respondents (20%) stated involvement in this activity while the remaining thirty two (80%) did not. The large percentage of respondents not participating in this activity is worrying and distressing.

Responses to activity 2.5.6.5:- identifying the strengths and diagnosing difficulties in the clinical teaching programmes

According to Mellish & Brink (1990: 316) it is essential that from time to time, nurse educators evaluate the clinical teaching programmes that they offer. This should be a joint effort, which means unit professional nurses should be involved as participants in the planning and execution of clinical teaching. They further suggest the following questions that should be asked and researched during this evaluation process, namely:-

- are we producing the end-product which is desired? Are the nurses registered as a result of the programme able to act effectively in professional practice?
- if not why not?
- Do the programmes meet the health needs of the community?

- Are the programmes flexible enough to allow individual teaching strategies to be used or are the programmes rigid and suppressive of individuality?
- Are the measures established for communication with the service side of nursing education satisfactory?
- Do nurse educators play a meaningful role in the clinical area?
- Are nurse educators encouraged and assisted to attend in-service and other updating offerings in practical aspects of nursing and on new advances on educational technology?
- Are nurse ducators encouraged to undertake self-evaluation and student evaluation of the courses they offer?

Table 5.20 and figure 5.7 depicts that scores in the ideal scale yielded positive respondents since all forty nurse educators (100%) viewed this activity as their ideal function. This response compares favourably with that in the actual scale because again all forty respondents (100%) indicated active participation in identifying strengths and diagnosing difficulties in the clinical teaching programmes.

The general response on the item of evaluation was satisfactory. This is

indicative of the fact that nurse educator do recognize the importance of evaluation in nursing, namely, to ensure that the student on completion of the course is a competent, knowledgeable, humane nursing practitioner capable of performing her independent as well as dependent functions with educated judgement. The highest score (100%) was recorded on activities evaluating progress made by individual students, evaluating effectiveness of evaluation tools and identification of strengths and diagnosing diffuculties in the clinical teaching programmes. The lowest and very disappointing score was recorded on activity seeking feedback from students with 2% involvement and 80% non-involvement.

5.6.5.7 Problems and constraints encountered by nurse-educators during clinical teaching

The purpose of this item was to establish whether there were any problems encountered by nurse educators during clinical teaching. This was essential because the presence or absence of problems could have either a positive or negative influence in the manner in which nurse educators implement their clinical teaching role. Against each problem, nurse educators were further asked to suggest a solution thereof. A number of problems were mentioned

and the ones checked more often than others are reflected in the table below.

TABLE 5.21 PERCENTAGE DISTRIBUTION OF PROBLEMS ENCOUNTERED BY NURSE EDUCATORS IN CLINICAL TEACHING

PROBLEMS	FREQUENCY	PERCENTAGE
Lack of equipment and supplies	31	77.5
Shortage of nurse educators	29	72.5
Overload with classroom teaching	23	57.5
Problems with semester system	08	20
Shortage of staff in the clinical area	07	17.5
Poor attitude of nurse educators towards clinical teaching	06	15

("Note") The scores in the above table will not add up to forty (40) or 100% because an item was checked by more than one respondent).

As depicted in table 5.21 above, the problem of shortage of equipment and supplies was checked by many respondents (77.5%) followed by shortage of nurse educators with 72.5% respectively. Overload with classroom teaching was checked by twenty three respondents (57.5%). This group further stated that the semester system brought about too much demands, namely setting of examination questions twice a year, marking and writing memoranda which

must be prepared and dispatched to the supervising universities for approval. Shortage of staff in the clinical area was checked by seven (17.5%) respondents. This problem of shortage of staff, was assumed by some respondents to be creating a situation where student nurses are made part of workforce in the units and therefore not available for clinical teaching. The lowest score (15%) was recorded in the problem of poor attitude of some nurse educators towards clinical teaching. To further qualify this latter assertion, few respondents stated that there are some nurse educators who feel that clinical teaching should be the responsibility of only those tutors teaching general nursing science and art.

Some of the afore-mentioned problems especially shortage of nurse educators and lack of equipment emerged in studies (1997) on clinical instruction in nursing colleges found in KwaZulu-Natal Province. For this reason, work studies to determine scientifically the staffing needs and the availability of equipment in nursing colleges of this province must be undertaken by the Department of Health.

Other problems that nurse educators mentioned include the following:-

- absenteeism of student nurses from the clinical area

- too large number of students making it difficult to provide individual attention
- models used for simulation too old
- lack of inservice education for nurse educators
- conflict among staff i.e. nurse educators
- poor participation of ward professional nurses in clinical teaching
- disorganised placement of students
- attitude of higher authorities
- congestion in the wards and lack of privacy
- lack of knowledge about clinical teaching by some ward professional nurses
- poor communication between nursing administration and nursing college personnel
- lack of clinical skills by some nurse educators
- lack of joint effort between student nurses unit professional nurses and nurse educators
- lack of motivation on the part of the student nurses. Some of the students have a negative attitude towards clinical placement
- nurse educators not updated with developments in the clinical setting.

Obviously problems are likely to occur in the clinical area because the wards are directed towards ensuring the best possible standard of patient care and are not primarily concerned with the needs of the learners. However, these problems need to be tackled head-on by nurse educators to ensure that effective clinical teaching takes place in the wards. This is important because nurse educators carry the responsibility for preparing practitioners of nursing of tomorrow.

Most of the afore-mentioned problems were identified by Hinchliff (1986: 53). She cite the following:-

- conflict between service demands and educational requirements
- overcrowding in the wards
- lack of equipment
- shortage of staff
- lack of motivation on the part of the student to increase knowledge and improve skills
- confusion on the part of the student caused by different approaches in teaching by different teachers.

The fact that problems mentioned by Hinchliff in 1986 are still experienced by nurse educators ten year down the line is an indication that probably very little or no effort has been made to resolve them.

Nurse educators were further requested to suggest solutions to problems and the following were put forth:-

- institutions for teaching nurses i.e. both hospitals and nursing colleges to be well supplied with equipment
- management of nursing colleges to motivate for more nurse educators
- wards to be adequately staffed with trained personnel so that students are not used as workforce
- nursing education programme to be a year system to allow students and teachers enough time for clinical teaching, accompaniment and evaluation thereof
- to avoid overcrowding in the wards, admission of patients should be balanced with discharges
- proper communication should be opened for all stakeholders in clinical instruction so as to be able to freely exchange information
- nurse educators must update themselves constantly about developments

in the clinical area

- continuous interactive workshops for student nurses, nurse educators and ward professional nurses to be encouraged. These will not only solve the problem of co-operation, but will also assist in defining the roles of personnel involved in the training of students as well as the role of the students in their own learning
- nurse educators to utilise all possible strategies to motivate students in developing a positive attitude towards clinical placements
- only professional nurses with adequate clinical exposure to be allowed to register as tutors, those with experience from two years upwards
- continuous motivation of nurse administrators to realize the need for correlation of theory to practice by tutors and not to look at the latter as "watchmen"
- supervisors to monitor progress of nurse educators
- striking a balance between classroom teaching and clinical teaching. At the moment more time is spent on classroom teaching, therefore curriculum needs to be revisited
- role of tutor in clinical teaching to be included in orientation and induction of "neophyte" tutor

- establishment of clinical teaching department to relieve nurse educators of unrealistic workload
- strict measures to be enforced to ensure that students are fulfilling their hours of allocation in the wards.

5.7 CONCLUSION

This chapter dealt with analysis, presentation, interpretation and discussion of research findings. The results of analysis of data have revealed that the majority of nurse educators under study do accept liability for clinical instruction but are unable to adequately fulfil this role because of numerous constraints some of which are imposed by clinical setting. It also emerged from analysis that some nurse educators are not fulfilling their clinical role because of negative attitude towards it. This is probably the group that relegate clinical instruction to a position of low priority and have lost sight of what a nurse educator really is.

CHAPTER SIX

6. REPORT ON CONCLUSIONS, LIMITATIONS, IMPLICATIONS OF THE FINDINGS AND RECOMMENDATIONS

6.1 INTRODUCTION

The aim of this chapter is to present a brief overview of the project. Areas that will receive attention will be summary of finding, conclusions, implications of the findings and recommendations for further studies.

6.2 SUMMARY OF THE STUDY

The discussion of findings will be preceded by a brief overview of the study with special reference to problem statement, objectives of the study, reviewed literature and methodology used to collect data. This will give the reader background information of the study in general.

6.2.1 Statement of the problem

The problem in this study is apparent lack of participation of nurse-educators in clinical instruction of student nurses.

6.2.2 Objectives of the study

The study aimed at achieving the following objectives:-

- to elicit the views of nurse educators regarding their role in clinical instruction
- to determine the extent to which nurse educators participate in clinical instruction
- to identify and describe what nurse educators consider to be the major constraints in clinical instruction.

6.2.3 Reviewed literature

Clinical instruction is an important component of the nurses educational programme. It provides the final input for learning, that is, interaction in an environment containing clients and other health professionals. It also enables the student nurse to learn why and how to help man in need of health care, bearing in mind that he is a unique individual in constant interaction with his situation (Woodward 1986:1).

According to Mashaba & Brink (1994:45) meaningful clinical teaching and learning requires the nurse educator to actually go along with student nurses

to either a simulation laboratory or clinical area in order to illustrate and demonstrate what and how to apply theory to a particular situation.

However literature reveals that the organisation of clinical instruction was previously left to the discretion of ward professional nurses and it tended to be haphazard (Robertson 1980:30). This assumption was confirmed by various studies. For instance, in a study conducted by Salvage (1985) as cited by Jinks (1984:1063) student nurses claimed that clinical teaching was provided on an ad hoc basis. The same results emerged in a study of Campbell (1991) where findings showed that the correlation of theory and practice was unsatisfactory and that clinical teaching was usually done in an unorganised manner (Mashaba & Brink 1994:47). It was for these and other reasons (e.g. inability of ward professional nurses to meet students learning needs because of alleged increased workload) that clinical instruction was made first and foremost the responsibility of nurse educators and to a lesser extent of the professional nurse in charge of the ward (Searle 1986:251). Nurse educator was seen as the teacher of nursing and therefore an expert in teaching in clinical settings as well as in the classroom. Some of the student nurses were of the opinion that the clinical teaching should be the

responsibility of nurse educators. For instance in a study conducted by Alexander (1983:136) student nurses stated that the integration of theory should be the responsibility of the college. Studies on clinical instruction reveal that this shift of clinical teaching was accepted by some nurse-educators. In a study conducted by Cele (1990:60) all nurse-educators under study agreed that they are responsible for all forms of nursing education and that they should therefore do clinical instruction. These findings almost tally with the results of a study on nurse educators' perception of their clinical instruction role conducted by Mchunu (1997:54) when the majority of nurse-educators (92.9%) indicated that clinical instruction belongs to nursing education and claimed to be actively involved in clinical teaching. However, some nurse educators do not accept the responsibility for clinical instruction. They are of the opinion that it should either be the responsibility of unit professional nurses or clinical instructors. In studies by Alexander (1983:139) and Mchunu (1997:54) the following reasons were given by these nurse educators as reasons of why they were not doing or should not be expected to do clinical teaching:-

- overburdened with college duties
- lack clinical skills and confidence

- ward staff resent their presence
- creation of the clinical teacher grade has made it easy for them to opt out.

Nursing literature reveals that opinions differ as to who should be responsible for clinical teaching. Mellish & Brink (1987:218) state that clinical instruction should be the responsibility of unit professional nurses because they have developed expertise in the clinical field. This view is contradicted by Reilly & Oermann (1985) as quoted by Mchunu (1997:14) when they state that clinical teaching is an indispensable dimension of nurse education and therefore the function of the nurse educator. The same sentiments are shared by Mashaba & Brink (1994:461) who assert that the ultimate responsibility for clinical teaching rests with nurse educators.

6.2.4 Methodology

6.2.4.1 Research design

The research design used to obtain information from respondents regarding their clinical instruction practice and problems there of was a descriptive survey. This method was chosen because it focuses on what people do.

6.2.4.2 Research instrument

Information was obtained from respondents by means of a questionnaire designed by the researcher. Questionnaire items were based on the objectives of the study and they were supported by information sought from previous studies related to clinical instruction practice of nurse educators. The questionnaire was divided into two section: Section A consisted of biographical, educational and professional data. Section B contained items on the views of nurse educators regarding their role as clinical instructors and the extent to which they are involved in clinical instruction. This section had double-barrelled Likert-type scale. On the ideal scale nurse educators were to state what they perceive to be their ideal function during clinical teaching. On the actual scale, the respondents were to indicate the extent to which they were involved in clinical teaching. The last question in Section B was on problems encountered by nurse educators during clinical instruction and suggested solutions thereof.

The questionnaire consisted of both open-ended and closed-ended questions. Before administration, the questionnaire was pre-tested on three nurse-educators to eliminate ambiguous or unclear questions, change phrasing where

necessary and eliminate confusing statements.

6.2.4.3 Population and sample

The population for this study consisted of nurse educators currently engaged in the education and training of student nurses undergoing the basic comprehensive four year diploma course at nursing colleges located in regions D; G and H in KwaZulu Natal. Participants consisted of thirty nine females and one male. Their ages ranged between twenty (20) to fifty nine (59) years. Permission for the study was obtained from appropriate authorities in the KwaZulu Natal Department of Health. Participants were assured of anonymity and confidentiality.

6.2.4.4 Process of data analysis

Closed-ended questions were analysed by means of a computer using Statistical Analysis Programme (SAP). Open-ended questions were analysed manually.

The Likert-type questions in the ideal scale were collapsed horizontally into three categories. Responses 1 (strongly disagree) and 2 (disagree) were

classified as "disagreeable". Responses 4 (agree) and 5 (strongly agree) were classified as "agreeable". Class three was "uncertain". In the actual scale, responses 1 (not at all) and 2 (minimally) were classified as "not involved" or "non-participatory". Responses 3 (reasonable), 4 (considerable) and 5 (a great deal) were classified as "involved" or "participatory". Data from horizontally collapsed codes was presented in the form of tables and bar graphs.

6.3 SUMMARY OF RESEARCH FINDINGS

6.3.1 Profile of nurse educators who participated in the study

6.3.1.1 Gender

The findings of this research revealed that out of forty nurse educator who participated in the study, thirty nine (97.5%) were females and only one (2.5%) was a male. This indicates that the nursing profession in KwaZulu Natal Province is still female dominated.

6.3.1.2 Age range

The findings of this research show that the majority of respondents (52.5%) belonged to the middle age group (30-39 years). It can be assumed that these

nurse educators possess adequate skills and experience as nurses. They are therefore probably mature enough to effectively teach student nurses in the clinical setting so that on completion of training they are safe practitioners of nursing.

6.3.2 Educational qualifications

Out of forty nurse educators who participated in the study, twenty five (62.5%) completed the post registration bachelors degree. It can be assumed from these findings that they possess a broader scientific educational and professional knowledge. They are probably cognizant of the fact that nurses educational programme includes teaching both theory and practical and therefore ready to accept the clinical teaching dimension.

6.3.3 Extent of clinical instruction practice of nurse educators

6.3.3.1 Involvement in clinical teaching

The majority of respondents (95%) indicated active involvement in clinical teaching of students in the clinical setting. This response is pleasing because it can be assumed that nurse educators are aware of the need to accompany student nurses in the clinical area.

6.3.4.2 Average time spent for clinical teaching

Out of forty respondents, sixteen (40%) responded that they spent 1 - 2 hours per week in clinical teaching and only five (12.5%) indicated to be spending eight hours and above per week. Time spent by the majority of respondents doing clinical teaching is probably too little to enable them to provide individual guidance and supervision of students.

6.3.3.3 Involvement of nurse educators in facilitation of learning in the clinical area

This item aimed at establishing the ideal and actual extent of involvement of nurse-educators in creating a supportive and facilitative milieu for student nurses in clinical area. Activities given in item 5.6.5.1 were accepted as ideal functions of nurse educators and the degree of acceptance ranged from 85% to 100%. Nurse educators who actually participated in these activities were however much less than expected. The highest score indicating participation was 47.5% and the lowest was 2.5%.

6.3.3.4 Involvement of nurse educators in the provision of motivation and support to students while in the clinical area

All activities listed in item 5.6.5.2 (provision of motivation and support to students in the clinical area) were accepted as ideal functions of nurse educators. The degree of acceptance ranged from 77.5% to 100%. Activities that yielded the most favourable responses were providing opportunities for students to develop professional decision making skills and judgement and assisting students to apply knowledge to varied clinical situations. Scores reflecting actual participation were disappointing. They ranged from 2.5% to 40%.

6.3.3.5 Reason for non-involvement in clinical teaching

Nurse educators who were "not at all" participating in clinical teaching stated that what they teach in class is totally removed from clinical reality and that they were overloaded with theory teaching.

6.3.4 Clinical instruction practice of nurse educators using the instructional process

Assessment for clinical teaching

Assessment of students in the clinical area was perceived by all respondents (100%) as their ideal function. The activity that yielded the highest score (100%) in actual participation was studying regulations and directives of the course offered. Otherwise in other activities poor participation was evident with scores ranging from as low as 17.5% to 55%.

Planning for clinical teaching

Responses of nurse educators to the extent to which planning was perceived as their ideal function yielded positive responses with 100% acceptance. Again, a positive response emerged in actual participation when all respondents (100%) stated involvement in all activities listed under this item (planning).

Implementation of clinical teaching

Implementation of clinical teaching was perceived by all respondents (100%) as their ideal function. In actual participation the activity that yielded lowest

response (5%) was accompaniment of students in the clinical area. The activities that received more attention were teaching according to set objectives and use of teachable moment with 100 and 80% respectively.

Evaluation of clinical teaching

The responses of nurse educators to the extent to which evaluation was perceived as their ideal function yielded very high scores with 100% in all activities listed. Although the activity on seeking feedback from students received a very low score (5%) participation in other activities ranged between 60% to 100%.

6.4 CONCLUSIONS FROM FINDINGS

Conclusions drawn from the findings of the study suggested that:-

- The majority of nurse educators working in institutions under study are mature people (both professionally and educationally) and therefore qualify for guiding student nurses to professional maturity. Their responses indicate that their personal characteristics (age, education and professional qualifications) might have a positive influence on their clinical instruction practice.

- A large percentage of respondents perceived clinical instruction to be their function.

- Assessment, planning, implementation and evaluation for clinical teaching were accepted as functions of nurse educators. This response proves nurse educators' perception of clinical instruction as their responsibility (objective 1).

- Nurse educators did not adequately participate in clinical instruction. Reasons given were overload of work, feeling that what they teach in class is removed from clinical reality and lack of clinical skills and confidence (objective 2).

- It also came to light that nurse educators who were keen to effectively execute clinical instruction could not do so because of various problems they encountered (objective 3).

6.5 LIMITATIONS

- Only three nursing colleges were selected for this study because of

financial constraints. Otherwise the researcher would have involved all nursing colleges in KwaZulu Natal Province.

- Some nurse educators failed to return the questionnaires despite a second visit by the researcher and several telephonic reminders. If all the questionnaires were returned, more light could have been shed on the issue of clinical instruction and the role of the nurse educator.

- Financial constraints also prevented the researcher from involving the recipients of clinical instruction, that is, student nurses. More views could have been elicited.

6.6 IMPLICATIONS OF THE STUDY

Assessment for clinical teaching

The findings of this study show that nurse educators working in institutions under study accept that assessment of students in the clinical area is their responsibility. They also indicated participation in this activity although scores reflecting participation were lower than those in the ideal scale. The questionnaire provides a guide on what is to be assessed for clinical teaching

(see annexure A, item 5.6.5.3).

Planning for clinical teaching

The findings of this study show that all nurse educators working in institutions that were studied acknowledge that planning for clinical instruction is their function. The same response emerged in the actual scale where all respondents (100%) indicated participation in planning for clinical teaching. These findings should be an indication that nurse educators can do as well in other phases of the instructional process.

Implementation of clinical teaching

The actual scale show high scores of non-participation in implementation of clinical instruction by nurse educators. Activities on the ideal scale should be used as a standard or yardstick against which they measure their performance in order to improve their participation in activities that they ideally perceive as their function.

Evaluation of clinical teaching

The findings in this item revealed that actual evaluation of students was

practised and scores were as high as those given in the ideal scale. Activities in item 2.5.6 of the questionnaire should help nurse educators to identify areas that need attention in evaluation of clinical learning.

A high degree of inconsistency in nurse educators' participation in the implementation of instructional process has been highlighted in this study.

Problems encountered in clinical teaching

This study could make nursing education leaders and principals of nursing colleges to be aware of problems encountered by nurse educators when teaching clinical nursing to students in the wards. The research report might serve in the Senate committees as a document to motivate for increase in human and material resources as these were some of the problems mentioned by nurse educators.

6.7 RECOMMENDATIONS

Based on the findings of this study, the researcher views the following recommendations as appropriate to eliminate some of the problems facing the clinical dimension of the nurses' education and training programme:-

- The educational preparation of nurse teachers should put emphasis on clinical teaching on an equal basis as it happens in theory teaching. For instance at present student nurse teachers are made to gain practice in theory teaching and nothing is really done about clinical teaching. This would hopefully change perceived negative attitude of nurse educators towards clinical instruction and eliminate its relegation to a position of low priority.

- A model of clinical instruction could be designed for nursing colleges in KwaZulu Natal Province to serve as guideline for nurse educators on clinical teaching. The model could include aspects such as the frequency of visits that nurse-educators should make to the clinical settings, the number of hours to be spent doing clinical teaching and the outline of activities that constitute adequate clinical teaching. This will probably ensure meaningful contribution by all nurse educators towards clinical instruction.

- Universities that offer nursing education courses should ascertain before admission that prospective student nurse teachers have acquired

adequate clinical experience as professional nurses. This would probably enhance the awareness of candidates of the fact that nurse educators are responsible for teaching student nurses how to physically nurse patients and clients and not how to theorise.

- Careful thought should be directed towards the utilisation of important strategies for clinical teaching such as "peer group" teaching where a senior student nurse teach junior student nurses. This would ensure continued clinical learning when the nurse ducator is bogged down with college duties.

Recommendations for further research

Further research could be conducted in other nursing colleges in KwaZulu Natal Province to establish if they experience the same problems mentioned by nurse educators of institutions under study. The research should involve student nurses because they are recipients of clinical instruction. This will give them a platform to air their views on clinical teaching and to bring forth solutions that they deem appropriate to resolve problems that bedevil clinical teaching.

6.8 CONCLUSION

The results of this study demonstrate that the majority of nurse educators under study are in principle aware of their obligation for clinical teaching. However, a number of factors militate against fulfilment of this obligation. Some nurse educators assert that clinical teaching should be a shared responsibility between clinical instructors and unit professional nurses. This clearly indicates that clinical teaching remains a controversial issue. The researcher believes that the results of this study allow for an improvement in quality of clinical involvement of nurse educators to ensure safety and quality of clinical learning experiences on the part of the students. The question is which solution may be considered best to remedy the situation? Perhaps that is why Infante (1987:181) says:-

> "There are no perfect and complete solutions to problems we face in clinical laboratory. No single formula will work well in every setting. Yet no excuses can justify perpetuating the problems of yesterday and today into tomorrow."

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University of Zululand.

ANNEXURE A

Enquiries: 93911 ext. 2454

University of Zululand
P/Bag X1001
KwaDlangezwa
3886

21 January 1999

The Principal
Ngwelezane Nursing College
P/B X20021
Empangeni
3880

Dear Madam

REQUEST TO CONDUCT A RESEARCH

I write this letter to kindly request permission to conduct a research study whereby the participation of nurse educators of Ngwelezane Nursing College and its two satellite campuses will be sought.

The research is a requirement for M Cur degree in Nursing Education and the title is **"A study of clinical instruction practice of nurse educators and problems thereof".**

Your cooperation will be highly appreciated.

Yours sincerely

....
T. Mtetwa

ANNEXURE B

University of Zululand
P/Bag X1001
KwaDlangezwa
3886

21 January 1999

The Regional Medical Superintendent
Ngwelezane Hospital
P/B X20021
Empangeni
3880

Dear Sir

REQUEST TO CONDUCT A RESEARCH

I kindly request permission to undertake research amongst nurse educators currently employed at Ngwelezane Nursing College and its satellite campuses namely, Benedictine Nursing College & Charles Johnson Memorial Nursing College.

The aim is to solicit the views of nurse educators regarding their clinical instruction practice and problems thereof. This is a requirement for M Cur degree in Nursing education.

Hoping my request will receive your favourable consideration.

Yours sincerely

....
T. Mtetwa

ANNEXURE C

H/W32/1/3

KWAZULU DEPARTMENT OF HEALTH

RECOMMENDATION AND APPROVAL FOR CARRYING OUT RESEARCH

1. Personal Details and Researcher

Name: THEMBI MTETWA Official Title: MRS

Address: UNIVERSITY OF ZULULAND

Employer: UNIVERSITY OF ZULULAND

2. Research Title: A STUDY OF CLINICAL INSTRUCTION PRACTICE OF NURSE-EDUCATORS AND PROBLEMS THEREOF

3. Recommendations by Institution/Regional Officer/Study Leader

This research study is recommended

T.G. Mashaba

4. Chairmam of Research Committee:

Remarks: not applicable!

Confirm that the project has been approved by the research Committee

SIGNED: .... DATE: ....

5. Superintendent or Regional Officer

Remarks: No objection

1. Confirm that use of facilities will not, in my opinion, disrupt the routine of the institution.

SIGNED: [signature] DATE: 23/9/94

6. Head of professional group of researcher:

Remarks: This research study is recommended

....

SIGNED: TG Mashaba DATE: 07.07.96

7. Head of Pharmaceutical Services. (In the case of clinical trials)

Remarks: not applicable

....

SIGNED: .... DATE: ....

8. HEAD OF DEPARTMENT

THIS PROJECT IS APPROVED / ~~NOT APPROVED~~

Remarks:

Conditions: ....

Copy of report to be submitted to this office

....

....

....

....

[signature] 23/9/96

pp SECRETARY FOR HEALTH DATE:

ANNEXURE D

Enquiries: 93911 ext. 2454

University of Zululand
P/Bag X1001
KwaDlangezwa
3886

21 January 1999

Dear Colleague

I am kindly requesting you to take part in my research concerning the clinical instruction practice of nurse educators and problems thereof.

Your participation is very important to the accuracy of this research. I sincerely hope that you will be willing to share your time and thoughts with me by providing the information requested on the questionnaire. All replies will be kept in strict confidence and no one will know the answers you have personally given. Do not write your name or the name of your institution anywhere on the questionnaire.

Thank you for your cooperation.

Yours sincerely

....
T. Mtetwa (Mrs)

SECTION A

BIOGRAPHICAL, EDUCATIONAL AND PROFESSIONAL DATA

Please answer each question by inserting a (X) in the most appropriate item block, unless otherwise specified.

1. GENDER

1.1	Male	
	Female	

1.2 Age group

1.	20 - 29 years	
2.	30 - 39 years	
3.	40 - 49 years	
4.	50 - 59 years	
5.	60 years and above	

2. NURSING EDUCATION INFORMATION

2.1 Type of Basic Nursing Programme completed

1.	South African Nursing Council Diploma Course	
2.	Integrated four-year diploma course	
3.	University Bachelors degree	
4.	Other (please specify)	

2.2 Type of programme completed when you first register as a nurse educator with the South African Nursing Council.

1.	University Diploma	
2.	Post registration Bachelor's degree	
3.	Other (please specify)	

2.3 Present highest professional qualification

1.	Post registration diploma(s)	
2.	Bachelor's degree	
3.	Honours degree	
4.	Masters degree	
5.	Doctoral degree	
6.	Other (Specify)	

2.4 Are you currently engaged in formal study beyond the highest degree which you hold?

Yes	
No	

If yes, please specify

....

....

....

....

3. PROFESSIONAL INFORMATION

3.1 Experience as a registered nurse before registering as a tutor

1.	Less than 1 year	
2.	1 - 2 years	
3.	3 - 4 years	
4.	5 years and more	

3.2 Field of nursing where you have acquired at least six months practical experience as a registered nurse before registering as a nurse educator

1.	Medical	
2.	Surgical	
3.	Paediatric	
4.	Midwifery	
5.	Psychiatry	
6.	Community health	
7.	Nursing Administration	
8.	Other (Specify)	

3.3 Position held for more than 1 year before doing the Nurse Educator's course

1.	Professional Nurse	
2.	Senior Professional Nurse	
3.	Chief Professional Nurse	
4.	Nursing Service Manager	
5.	Other (Specify)	

SECTION B

1. VIEWS OF NURSE EDUCATORS REGARDING THEIR ROLE AS CLINICAL TEACHERS/ INSTRUCTORS

1.1 Do you think clinical instruction should be the responsibility of Nurse Educators?

Yes	
No	

1.2 If your response to the above item is "NO" state the reason(s) why, and indicate whose job do you think it should be

....

....

1.3 If your response to item 1.1 is "YES", please motivate your answer

....

....

....

1.4 Previously, clinical instruction has been the responsibility of clinical instructors. What is your opinion regarding this practice, was it ideal or the status quo should remain?

....

....

....

2. EXTENT OF INVOLVEMENT OF NURSE EDUCATORS IN CLINICAL INSTRUCTION

2.1 Do you participate in clinical instruction?

Yes	
No	

2.2 If your response to item 2.1 is "YES" indicate reasons for participation

Part of job description	
Necessary for integration of theory into practice	
Necessary for the development of skilled, safe practitioners	
Other (Specify)	

2.3 (Only for "YES" response 2.1) How many hours on average, 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	

2.4 If your response to item 2.1 is "NO" indicate reasons for non-participation

Overloaded with classroom teaching and other college-based duties	
Lack of proficiency in clinical skills	
Feeling that what Nurse Educators teach in class is removed from clinical reality	
Not the responsibility of Nurse Educators	
Other (Specify)	

2.5 Please answer each question by making a cross (X) in the appropriate item block and indicate the following:-

2.5.1 SCALE 1 The degree to which you agree/ disagree with the statements reflecting what you think ought to be done

2.5.2 SCALE 2 The extent to which you are actually involved in the execution of clinical teaching duties

2.5.3 Make a cross on both scales i.e. Scale 1 (for Ideal Situation) and Scale 2 (for the Actual Situation)

KEY

IDEAL SCALE

1 Strongly Disagree : Complete disagreement with the statement
2 Disagree : Disagree with statement with some reservations
3 Uncertain : Not sure whether to agree or disagree
4 Agree : Agree with some doubt
5 Strongly Agree : Completely agree with statement

ACTUAL SCALE

1 : Not at all
2 : Minimal (the least possible)
3 : Reasonable (not very much more or less than expected)
4 : Considerable (significantly more time is spent on this aspect)
5 : A great deal (beyond the ordinary to a large extent)

EXAMPLE : Assessment for clinical teaching

	IDEAL					ACTUAL				
	1	2	3	4	5	1	2	3	4	5
Assessment of learning needs of students					X			X		

	IDEAL					ACTUAL				
	1	2	3	4	5	1	2	3	4	5
2.5.1 NURSE EDUCATOR AS THE FACILITATOR OF LEARNING IN THE CLINICAL AREA										
2.5.1.1 Guiding ward professional nurses on teaching and learning in the wards										
2.5.1.2 Contributing to ensuring a safe physical environment, e.g. * prevention of accidents										
* promoting good student/ patient relationship										
* promoting good student/ professional nurse relationship										
2.5.1.3 Availing yourself to ward personnel as a resource person in the clinical area										
2.5.1.4 Counselling ward personnel on problems related to clinical teaching and learning										
2.5.1.5 Checking that facilities and equipment for use in teaching nursing skills are adequate										
2.5.1.6 Encouraging unit professional nurses to participate in clinical instruction to supplement your role										
2.5.2 PROVISION OF MOTIVATION AND SUPPORT TO STUDENTS IN THE CLINICAL AREA										
2.5.2.1 Providing students with opportunities to varied clinical situations										
2.5.2.2 Assisting students to apply knowledge to varied clinical situations										
2.5.2.3 Providing guidance to students about, e.g. * implementation of policies										
* completion of workbooks										
2.5.2.4 Providing opportunities for the students to develop professional decision making skills and judgement, e.g. when and why to call a doctor										

	IDEAL					ACTUAL				
	1	2	3	4	5	1	2	3	4	5
2.5.2.5 Rewarding students for creativity, e.g. making an effective suggestion about a new/ novel approach to a problematic situation										
2.5.2.6 Allowing for freedom of expression and taking of initiative in the acquisition of abilities										
2.5.3 ASSESSMENT FOR CLINICAL TEACHING										
2.5.3.1 Assessment of learning needs for clinical teaching:- * psychomotor										
* affective										
* cognitive										
2.5.3.2 Interviewing students to ascertain prerequisite knowledge										
2.5.3.3 Identification of needs according to individual learner and level of training										
2.5.3.4 Suitability of placement in relation to level										
2.5.3.5 Studying regulations and directives of the course offered										
2.5.3.6 Correlation of your assessment with the requirement of the controlling bodies										
2.5.4 PLANNING FOR CLINICAL TEACHING										
2.5.4.1 Planning of the clinical teaching programme										
2.5.4.2 Planning and setting objectives for clinical teaching										
2.5.4.3 Planning/ preparing of evaluation instruments										
2.5.4.4 Planning for evaluation of students clinical proficiency										
2.5.4.5 Planning of in-service education programmes for ward personnel pertaining to clinical teaching										
2.5.4.6 Ensuring that clinical teaching/ learning keeps up to date with latest developments, e.g. introducing new approaches to teaching and caring										

	IDEAL					ACTUAL				
	1	2	3	4	5	1	2	3	4	5
2.5.5 IMPLEMENTATION OF CLINICAL TEACHING										
2.5.5.1 Accompaniment of students in the clinical area										
2.5.5.2 Demonstration of nursing skills to students										
2.5.5.3 Supervising the correct and appropriate completion of clinical workbooks										
2.5.5.4 Creating opportunities for students to do proficiencies										
2.5.5.5 Making best use of appropriate teaching methods, e.g. * use of teachable moments										
* discussion of case studies in clinical area										
* teaching according to set objectives, etc.										
2.5.5.6 Ensuring maximum integration of theory and practice										
2.5.5.7 Consulting ward personnel to discuss problems/ needs related to clinical instruction										
2.5.5.8 Implementing research findings on clinical teaching and learning										
2.5.6 EVALUATION										
2.5.6.1 Evaluating progress made by individual student, i.e. formative evaluation										
2.5.6.2 Taking the lead in conducting clinical examinations										
2.5.6.3 Seeking feedback from students										
2.5.6.4 Evaluating the effectiveness of evaluation tools										
2.5.6.5 Identifying the strengths and diagnosing difficulties in the clinical teaching programmes										

2.5.7 PROBLEMS AND CONSTRAINTS IN CLINICAL TEACHING

List problems and constraints encountered during clinical teaching and suggest solutions for each problem

PROBLEMS/ CONSTRAINTS	SUGGESTED SOLUTIONS
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Thank you for your cooperation.